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CITY OF ABERDEEN.

REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1956

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MEDICAL OFFICER OF HEALTH

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ABERDEEN:

PRINTED BY G. CORNWALL & SONS.

MCMLVII.

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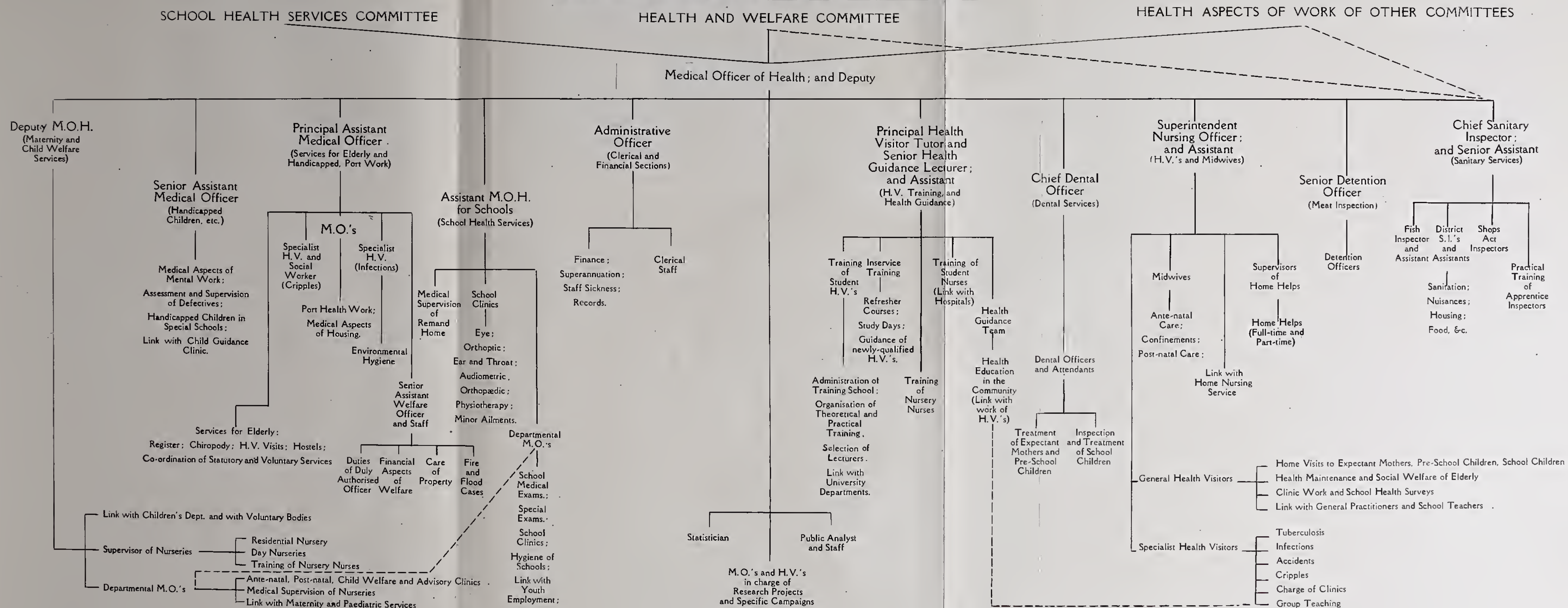
CITY OF ABERDEEN.

SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1952-56:—

	1952.	1953.	1954.	1955.	1956.
Population estimated to middle of year . . .	183,626	185,232	185,725	186,352	186,396
Marriage rate per 1,000 population . . .	10·5	10·4	10·2	10·6	10·5
Birth rate per 1,000 population . . .	16·5	16·6	17·4	17·2	17·5
Illegitimate birth rate per 100 births . . .	5·7	4·5	4·3	5·4	5·3
Still-birth rate per 1,000 total births . . .	18	20	19	12	21
Infant mortality rate per 1,000 live births . .	30	27	22	21	22
Neo-natal mortality rate per 1,000 live births .	18	19	15	11	14
Death rate per 1,000 population . . .	11·7	11·3	11·1	11·5	11·6
Malignant diseases death rate per 1,000 population	2·28	2·00	1·80	2·19	2·07
All tuberculosis death rate per 1,000 population.	0·22	0·16	0·12	0·09	0·10
Respiratory tuberculosis death rate per 1,000 population	0·20	0·14	0·10	0·08	0·10
Principal epidemic disease death rate per 1,000 population	0·03	0·02	0·03	0·04	0·02
Average age at death (in years) . . .	64·6	65·1	66·3	66·7	65·9

DIAGRAM SHOWING STRUCTURE OF HEALTH AND WELFARE DEPARTMENT



PREFACE.

Judged by the common indices of community health Aberdeen retains the position that it has held for several years as the healthiest of the Scottish cities. There is, however, a grim contrast between the statistics and progress of 1956 and those of the three previous years: in 1953, 1954, and the earlier portion of 1955 the professional staff of the Health and Welfare Department was steadily expanding, the story of each year was essentially one of developments and extensions of services, and each year the vital statistics of the City were better than ever before. In 1956 (and to some extent in the latter portion of 1955) the number of unfilled vacancies on the establishment of the Department was increasing; although there were many developments and extensions there were also contractions and regressions; the buoyant optimism that had imbued members of staff in the years when the services were improving spectacularly was replaced by a fierce determination not to allow the level of the health and social welfare services to fall unduly; and the vital statistics of 1956 were almost uniformly less good than those of 1955.

Nevertheless, it would be wrong to think of 1956 as merely a year of stubborn effort to hold ground gained in 1954 and 1955. 1956 was also the first year in which the Department was fully geared for work in the prevention of mental and emotional diseases, the year of the introduction of group teaching in the health field on a hitherto unprecedented scale, the year that witnessed the complete success of the Corporation's policy of decentralisation, and the year in which the numbers of home visits paid by health visitors, the numbers of attendances at clinics, the number of old people receiving the benefit of services, and the proportion of children protected against various preventable diseases all rose to heights considerably above those ever reached in the past.

The Report here presented deals with the health of the City and the activities of the Health and Welfare Department during 1956, except that the portion relating to the school health service covers the school year 1955-56. Although the order of the chapters has been altered and two additional chapters have been inserted, dealing respectively with housing in relation to health and with home accidents, the lay-out follows the same general lines as in the Report for 1955; and, for the convenience of those who may not wish to read each chapter in its entirety, the main chapters are each prefaced by an introductory paragraph which outlines the principal features of the year.

The remainder of this preface is divided into six sections dealing successively with the pattern of the year, developments and progress, contraction and regression, central overcrowding following peripheral expansion, some financial aspects, and miscellaneous matters.

THE PATTERN OF THE YEAR.

PATTERNS OF
PREVIOUS
YEARS.

In 1953 the pattern of the year was clear, the main threads being expansion and progress, and the vital statistics being described as "on the whole the best yet recorded for the City." In 1954, which a local newspaper termed "the year of records," the pattern was similar and the statistics were described as "so much better than those for 1953 as to be almost unbelievable." In 1955 the vital statistics were even better than in 1954—new low records being established for the still-birth rate, neonatal death rate, infant death rate, total loss of young lives, maternal death rate, tuberculosis death rate, &c.—but there were menacing clouds on the health horizon; clouds that made it necessary to write in the Annual Report for that year—

"Unless drastic steps are taken speedily at national level to improve both the quantity and the quality of recruits to the public health service, we are likely—instead of advancing to new health records in the years to come—to look back nostalgically at 1954 and 1955 as by far the healthiest years in our City's history."

COMPLEX
PATTERN
OF 1956.

In 1956 no such drastic national steps were taken. **The qualitative and quantitative shortage of professional staff, especially of health visitors, continued; the year's vital statistics were less good than in 1955 and in some cases less good than in 1954; and three distinct threads can be distinguished in the pattern of the year—(a) development and progress; (b) contradiction and deliberate omission; and (c) central overloading following peripheral expansion.**

SIMULTANEOUS
EXPANSION
AND
CONTRACTION—
AN EXAMPLE.

It may be a little difficult for some people to understand how the first thread—development, progress, and the undertaking of duties that were previously not carried out—can exist simultaneously with the second thread—contraction and conscious failure to perform certain tasks that should be undertaken and that were carried out in the past. Perhaps a simple example may illustrate. Let us, therefore, think of a hypothetical district of the City staffed in 1954 by six health visitors. Of these six in 1954 one is approaching the age of retirement; another is beginning to feel that she could have an easier life, could earn more money, and could have better prospects of promotion, by ceasing to use her health visiting training and returning to hospital work with its fixed hours, regular reliefs, and all the amenities of residential life; and a third is thinking vaguely of emigrating to a country in which preventive workers are reasonably remunerated. These six in 1954 are conscientiously and thoroughly carrying out their duties in respect of controlling infectious diseases and advising on the physical needs of expectant mother, baby, toddler, and school child; but—because they are fully occupied with these tasks—they are only vaguely aware that they also have functions relating to the prevention of juvenile delinquency and psychoneurosis, the prevention of broken homes, the promotion of emotional health and social well-being, the maintenance of health of elderly citizens, the prevention of home accidents,

and so forth. In the three years 1954-56 the staff of that district and the attitudes of the staff are altered in several ways: in 1954 a study week-end on the elderly, a campaign against home accidents, and an intensive course on mental health make them more aware of duties previously neglected, and the oldest of the six retires and is replaced by a newly-trained health visitor well equipped for work in these fields; early in 1955 a second newly-trained health visitor joins the staff and the team of seven find that they now have time to pay some attention to the emotional needs of the toddler and the social problems of the elderly citizen; at the close of 1955 one of the original six succumbs to the lure of better pay and easier work in the curative field and, early in 1956, another emigrates to Canada, so that for a time the team falls from seven to five; and later in 1956 another newly-trained health visitor joins the staff.

At the close of 1956 there are in that district the same number of health visitors as there were in 1954; but in the interval, and particularly in the period when the staff was seven, they have begun to undertake duties previously ignored—such as accident prevention, advice to the elderly, and promotion of mental health; and, when the numbers fell again, they have of necessity contracted their work—deliberately paying less attention than is desirable to some of their duties. Thus, for instance, a remote contact of a case of paratyphoid fever would be fully investigated in 1954 (time being available for such investigation because many duties were not yet assumed) but, in 1956, faced with a choice between investigating a similar contact (with a very slight possibility of an outbreak of paratyphoid fever if the investigation is not made) and helping a family on the verge of breaking (with the virtual certainty of a broken home if the help is not given), the health visitor may—with the complete approval of her Superintendent and of the Medical Officer of Health—decide to take the calculated risk of delaying or even omitting the investigation of the contact.

Leaving the example and turning to the services as a whole, it may be useful to consider them under the heads already indicated.

DEVELOPMENTS AND PROGRESS IN 1956.

To describe all the developments would involve summarising a large portion of the Report that follows. A few of the main points are, however, outlined below.

(1) Work in the Field of Mental Health.

It is nowadays universally accepted that **the family health visitor**—primarily concerned (in the phrase of the Government's Working Party on Health Visiting) with "health teaching and social advice"—**can do much to prevent maladjustment, child neglect, broken homes, juvenile delinquency, antisocial behaviour, and psychoneurotic and psychosomatic disorders**; and the modern health visitor is well trained for such work. Aberdeen's specific achievement in 1954 and 1955 was the gearing up of older health visitors by the provision of intensive courses in mental health, a feature which has been described as **"incomparably the most**

PREVENTION
OF
DELINQUENCY,
BROKEN
HOMES, &c.

important development in any recent year," by comparison with which "things like the introduction of immunisation against diphtheria and tuberculosis fade into relative insignificance."

1956 was the first full year in which virtually all the health visitors were equipped for their tasks in the field of mental work. Faulty parent-child relationships in the first six or seven years of life (*e.g.*, to take obvious instances—forcing, over-strictness, mollicoddling, inconsistency, or creation of avoidable sibling jealousy) may produce no immediately visible harmful results, but may so damage the growth of the personality that the child shows signs of maladjustment at 8 or 9 years, or becomes a delinquent at 13 years, or at 20 years has a nervous breakdown (precipitated by some strain that a more robust personality could have withstood), or at 25 years is unable to have normal marital relationships. Consequently, since these harmful effects usually do not appear for years, it is quite impossible at this stage to produce evidence about the value of the work now being done. Certainly, in 1956, fewer children were referred to the child guidance clinic, but this reduction in the apparent incidence of maladjustment might be coincidental.

(2) Introduction of Health Guidance.

GROUP
TEACHING ON
PHYSICAL AND
EMOTIONAL
NEEDS.

Nothing can supersede the teaching of individual persons and individual families—by the family health visitor in the privacy of the home and by public health medical officer and health visitor in the clinic, supplemented from time to time by the efforts of workers less immediately concerned with the teaching of health, such as the clergyman, the school teacher, the general medical practitioner, and the social worker. Group instruction is, however, a most useful reinforcement to individual teaching, and saves both time and money. If, as has been said "**the main function of a Health Department to-day is health education, using both words in the widest possible sense,**" the setting up of a **Health Guidance Section in the Health and Welfare Department in the autumn of 1956, can undoubtedly be regarded as the second biggest development of any recent year.**

By the end of December, eight simultaneous courses of meetings for expectant mothers had been organised; one health club for parents was well established, another was starting, and a third was being planned; health teaching at the ordinary child welfare clinics has been much developed and sporadic talks on health subjects were being delivered to many preformed audiences. The numbers attending were considerably higher than had been expected; and it could certainly be claimed that what the *Aberdeen Press and Journal* termed the "**thousand salvo blitz on disease**" had got off to an excellent start.

(3) Opening of New Clinics.

The Corporation's first purpose-built clinic (for ante-natal, child welfare, and school health purposes) was opened at Holburn in February, and a second, larger

HOLBURN AND
NORTHFIELD
CLINICS.

clinic was opened at Northfield in June. Additional clinic sessions were also started at various peripheral clinics.

By the end of the year, there were child welfare clinics in twelve areas (seven of them full-time or virtually full-time), not counting the mobile clinic; ante-natal clinics in five areas (equivalent to 25 single sessions weekly); post-natal clinics in five areas; a full-time gynæcological advisory clinic; and a full range of school health service clinics—for minor ailments, diseases of ear and nose, diseases of the eye, &c.

These clinics are, of course, **primarily educational**, rather than therapeutic in purpose.

(4) Success of Decentralisation.

1956 saw the full fruits of the policy of decentralisation. In 1954, the health visitors undertook 108,418 home visits; in 1955 (when decentralisation started), approximately the same number of health visitors paid 123,864 home visits; in 1956, about the same number of health visitors (fewer health visitors in the early part of the year and a shade more in the latter months) paid 143,185 home visits. This increase is the more remarkable in that, in 1956, there was a considerable rise in the proportion of visits to elderly citizens, and such visits are almost proverbially time-consuming. The policy of **taking the services to the people** may also be responsible for the two developments mentioned immediately below.

(5) Record Attendances at Clinics.

In 1955, the numbers attending the ante-natal, post-natal, child welfare, and gynæcological advisory clinics had been higher than ever before; but in 1956, the number of attendances at post-natal, child welfare, and gynæcological advisory clinics rose to still higher levels.

(6) Improvement in Numbers Immunised.

For the fifth consecutive year, there was an increase in the percentage of children protected against diphtheria; and there were also increases in the numbers and percentages protected against smallpox and whooping cough.

(7) Introduction of Vaccination against Poliomyelitis.

During the year, protection against poliomyelitis was made available, though supplies were very short and uncertain throughout the year.

(8) Relaxation Exercises for Expectant Mothers.

During the year, relaxation exercises were made available for expectant mothers. Obstetricians still argue about whether such exercises really make the mechanism of labour any easier, but public health medical officers and health visitors are unanimous in the considered opinion that the exercises improve the physical health of the women as well as being of considerable psychological benefit.

(9) Developments in the School Health Service.

BETTER CARE
OF SCHOOL
CHILDREN.

Developments in the school health service included **an increase in home visiting** of school children, **more attention to emotional problems and human relations**, the provision of **physiotherapy** for physically handicapped children at Beechwood School, and an increase in the number of children receiving **orthodontic treatment**.

(10) Services for the Elderly.

ELDERLY—
VISITS BY
HEALTH
VISITORS;

Investigations in previous years had suggested that **the commonest un-met need of elderly citizens was for visits by health visitors** (to advise on measures to maintain or improve physical and emotional health, to offer guidance about social problems, and to act as initiators and co-ordinators of health services or social services needed by the individuals). In 1956, the number of elderly citizens being visited by health visitors rose to 2,320 (as compared with 1,238 in 1955). This steady expansion has probably done **more than any other single measure to improve the health of elderly people**.

REGISTER;
HOME HELPS;
CHIROPODY.

The number of persons on the **register of elderly citizens** maintained by the Health and Welfare Department also increased; **the home help service was enlarged**, and the **chiropractic service** was also extended. There was, in addition, some increase in the number of meals supplied by the **mobile meals service**.

(11) Food Hygiene.

CLEAN FOOD
GUIDE.

Medical, health visiting, and sanitary staff strove to raise the level of food hygiene among all food handlers—commercial and domestic. During the year, members of the staff prepared material for the **Aberdeen Clean Food Guide** (issued early in 1957).

(12) Some Research Projects.

RESEARCH
STUDIES.

During the year, the **research into home accidents** (largely financed by a grant from the Nuffield Trust) and the **research into simultaneous immunisation** against diphtheria, whooping cough, and tetanus (entire cost defrayed by the Advisory Council for Medical Research) continued. In addition, a detailed study was begun of a five per cent. sample of all **elderly persons** in the City—to facilitate more exact determination of the needs of citizens of mature years; an **investigation of families with multiple problems** was started; and various minor research projects were undertaken.

(13) Training of Health Visitors.

If the health visitor is really (in the words of the Royal Society of Health) “the spearhead of the social service,” if she is really

“now concerned with the health care of the whole family, with the prevention of both physical and mental diseases, and with advice on matters

ranging from the weaning of the baby and the behaviour difficulties of the toddler, to the problems of family budgeting and the maintenance of morale in the elderly,"

then, manifestly, facilities for her training must be in no way inferior to the facilities for the training of members of other professions.

Although aware of the remarkable results obtained by the Aberdeen Health Visitor Training School (*e.g.*, a hundred per cent. pass in four consecutive years and top place in the national examination in three of these years), the Corporation appreciated that it was unsatisfactory for the post-qualification course for nurses and midwives training as health visitors to be shorter in Scotland than in England and Wales. Accordingly, a decision was taken in 1956 to extend the length of the course as from 1957.

LENGTHENING
OF HEALTH
VISITOR
TRAINING.

CONTRACTION AND REGRESSION IN 1956.

(1) Grave Shortages of Professional Staff.

Throughout 1956, the grave national shortages of professional staff continued; the shortage of sanitary inspectors was officially assessed at ten per cent.; the shortage of dental officers was much greater; and a Government Working Party in 1956 reported that, for a number of years, Britain had been training annually only a shade over one-half of the minimum number of health visitors needed to create or maintain an adequate disease-preventing service. Moreover, the survival of more elderly people and the relatively high birth-rates of the last ten years have caused a considerable rise in the numbers of individuals in the two groups with whom health visitors are most occupied—children and old people.

DANGER OF
COLLAPSE
OF HEALTH
SERVICE.

Aberdeen shared in the national shortages. For example, in January, the Corporation had actually **fewer health visitors than at any time since the middle of 1954**, and a special report was submitted to the Corporation in February. In the middle of the year, the local situation was temporarily improved by Aberdeen securing about 12 per cent. of all the health visitors in Scotland who had just completed their training, but by the end of the year the numbers were again beginning to decline, and a further special report was submitted early in 1957.

In the Annual Report for 1955, the causes and probable effects of the qualitative and quantitative shortages of professional staff were set out at length, but it may be worth while to summarise a few points here:—

- (a) If diphtheria immunisation (dependent mainly on the persuasive efforts of health visitors) collapses, we may well return to the 1940 Aberdeen figure of 586 cases and 21 deaths; and treatment of these cases would cost over £30,000, or more than the present cost of the whole health visitor service.

ECONOMIC
IMPLICATIONS.

- (b) If the collapse of the home safety campaign through lack of health visitors were followed by an increase of accidents to the extent of 24 per week, the annual cost to the community would be about £28,000, to say nothing of needless suffering.
- (c) By maintaining the health of elderly citizens, Aberdeen has been able to reduce by 150 places the total hostel accommodation originally calculated as necessary for frail old people; if the policy of health maintenance collapsed, through lack of health visitors, the annual cost of the additional 150 places would exceed £30,000.
- (d) If the collapse of the health visiting service results in fifty additional families (or one-fifth of our problem or borderline families) reaching the stage at which the children have to be taken into care, the additional annual cost will exceed £30,000.

In short, **the collapse of the public health service will cripple the community financially as well as producing a vast amount of needless suffering.**

On the other hand, to raise the quality and quantity of recruitment by increasing salaries to levels comparable with those in other professions (*e.g.*, by giving increases ranging from £230 for rank and file health visitors to £600 for top-ranking superintendents and tutors) would cost about £17,000 a year for Aberdeen—an amount that seems trivial by comparison with the sums that have been expended on other professions.

(2) Less Satisfactory Vital Statistics.

On a long-term basis, the association between the recognised indices of health and degree of adequacy of staffing is unquestionable. For example, in the Report for 1955, the question was considered in detail. It was shown that chance variation, alterations in the standard of living, changes in social class distribution, housing changes, climatic factors, and alterations in medical treatment or in facilities for treatment would not explain why, for three successive years, the vital statistics of Aberdeen had improved dramatically while those of Scotland as a whole had undergone little change. It was pointed out that there was a close correspondence between increases in health-promoting staff and better statistics; that a study of the past history of Aberdeen showed a similar relationship; that national figures also showed this correspondence; that two statistical analyses published in the Health Bulletin of the Department of Health for Scotland provided strong supporting evidence; and that Sweden—spending less per head of population on health and disease than does Britain, and employing relatively fewer hospital doctors, hospital nurses, and general medical practitioners—was the supreme example of really generous provision of public health staff (especially health visitors) and of phenomenally low mortality rates. It was concluded that **the evidence is therefore overwhelming that the main cause of the**

progressive improvements in Aberdeen's vital statistics in recent years is the expansion of the professional staff of the Health and Welfare Department.

In considering a regression in a single year, one is naturally on less firm ground, since chance variation cannot be ignored. Nevertheless, it would be stretching coincidence to abnormal lengths to assume that chance variation accounted for a whole series of deteriorations. All the recognised indices of community health—the infant death rate, the still-birth rate, the perinatal death rate, the average age at death, and the World Health Organisation's suggested health indicator—show that **Aberdeen was a little less healthy in 1956 than in 1955**, and the obvious explanation would appear to be the increased shortage of health visitors and other health officers. Nevertheless, it is fair to add that shortages are not the whole explanation: in the months of February to April, Aberdeen shared with most other east coast towns a considerable wave of respiratory diseases and this wave played some part in increasing the various death rates.

Moreover, it would be wrong to over-estimate the deterioration. Aberdeen, in 1956, was only slightly less healthy than in the record year, 1955, and **its vital statistics remained better than those of the other Scottish cities**. The regression is not an indication that collapse has occurred: so far, decentralisation and re-deployment of health visitors and a measure of dilution with less highly qualified staff have prevented serious damage. The regression is rather a mild signal of things to come—a **herald of the collapse that is impending**. It may well be that it is now too late to avert that collapse, and that, even if measures are at last taken to bring to the disease-preventing services an adequate number of recruits of sufficient calibre, we will have to pay—in deaths, in suffering, and in greatly increased provision of treatment facilities—for the long years in which the preventive services have been grossly undermanned.

(3) Examples of Inevitable Omissions.

One of the most potentially useful research projects begun in 1954 was a detailed, long-term **study of all children born in 1953**. Owing to shortage of health visitors, the study was discontinued at the beginning of 1956.

In the financial estimates for 1955-56, provision was made for a vigorous **diphtheria immunisation campaign** in the spring of 1956. Owing to lack of staff, the campaign was not undertaken, and the sum allocated was carried forward to the estimates for 1956-57. By the end of 1956, however, it was obvious that shortage of staff would make it impossible to conduct the campaign in the spring of 1957.

Similarly, a **clean food campaign**, originally planned for the summer of 1956, was quietly jettisoned.

(4) Tasks Ahead.**TASKS FOR
THE FUTURE.**

It is a melancholy commentary on 1956 that the following paragraph can be (with the exception of two phrases in brackets) reprinted word for word from the Report for 1955:—

“Some of the tasks ahead are the development of health guidance (started in November, 1956), the provision of a clinic for the early diagnosis of deafness, the setting up of an occupation centre for the physically handicapped, the provision of maternity and child welfare clinics in certain districts, the provision of physiotherapy both relaxation exercises for expectant mothers and physiotherapy for physically handicapped children (started to a limited extent in 1956), and the creation of one or more occupation centres for the mentally handicapped. Apart, however, from the difficulty of securing suitable premises, there looms ahead with ever increasing menace the problem of staff shortages.”

CENTRAL OVERCROWDING FOLLOWING PERIPHERAL EXPANSION.

In the years 1952-56, there has been a very great increase in the services provided by the Health and Welfare Department. For example—

**EXPANDING
SERVICES.**

- (a) In 1952, the Corporation had two hostels for old people; by the end of 1955, it had six.
- (b) From 1953 onwards, a register of old people has been maintained, increasing in size each year.
- (c) Chiropody has extended year by year from a service needing roughly half the time of a chiropodist to one employing the equivalent of more than two full-time chiropodists.
- (d) Immunisation has been made available against whooping cough (1953), tuberculosis (1953), tetanus (1955), and poliomyelitis (1956).
- (e) New services have been provided by the appointment of an audiometrician (1953), an orthoptist (1955), and a physiotherapist (1956).
- (f) Services for the physically handicapped and a register of handicapped adults were initiated at the end of 1953.
- (g) In 1954, Pitfodels Residential Nursery was enlarged considerably.
- (h) During 1954-56, additional clinic sessions were instituted at various centres and in 1956 new clinics were opened at Holburn and Northfield.
- (i) To such extent as staffing shortages permitted, health visitors have, bit by bit, undertaken new duties related to the promotion of mental health, the prevention of break-up of families, the more effective home visiting of school children, and the health and social well-being of the elderly.

- (j) In the last two years, the home help service has almost doubled—from 80 in 1954 to 150 just after the close of 1956.
- (k) In 1955, the Corporation assumed responsibility for the issue of cod liver oil and other welfare foods.
- (l) In 1955, the health visitor training school was enlarged and, in 1956, the course of training was lengthened.
- (m) In 1956, a mammoth scheme of group health teaching was put into operation.
- (n) The new food legislation placed additional duties on various members of staff.

Such increases in services inevitably caused parallel increases in the amount of administrative and clerical work. At first this work was tackled by vigorous re-organisation of the work of the existing staff and the appointment of two additional clerks; but, by 1956, an unfortunate paradox was apparent. The increase in central work clearly necessitates the appointment of an administrative assistant, an additional senior clerk, and several general grade clerks; but the Health and Welfare Department headquarters at Willowbank House is already overcrowded—to the extent that efficiency is sometimes impaired.

The Corporation has sanctioned the building of a prefabricated annexe adjacent to Willowbank House, and this would relieve overcrowding and enable some space to be found for additional staff. Unless, however, the annexe can be constructed very speedily, it will be necessary to hire some rooms as temporary additional accommodation.

SOME FINANCIAL ASPECTS.

(1) Actual Costs as Percentage of Rates.

Despite the expansions and extensions mentioned above, the cost of the Health and Welfare Services has not risen in proportion to the cost of the municipal services generally. In 1949-50, 6.88 per cent. of the City Rate was allocated to Health and Welfare; in 1956-57, the percentage so allocated is 6.51.

HEALTH COSTS
HAVE RISEN
LESS THAN
OTHER
MUNICIPAL
COSTS.

These figures can perhaps be more easily understood if expressed thus:—The total City Rate for 1949-50 was 13s. 0½d. per pound; the total rate for 1956-57 is 23s. 7½d.; and the increase from 1949-50 to 1956-57 is 81.15 per cent. The allocation to Health and Welfare in 1949-50 was 11.08d. per pound; the allocation in 1956-57 is 18.45d.; and the increase from 1949-50 to 1956-57 is only 66.2 per cent.

The sweeping increase in the portion of the City Rate allocated to Housing perhaps makes the above comparisons a little unfair, but it is interesting that, in a period when the expenditure on the Children's Department has increased by 171 per cent. and that on Fire Services has risen by 97 per cent., the cost of Health and Welfare has gone up by only 66 per cent.

(2) Comparison of Cities.

Even more startling (in view of the fact that the disease-preventing staff in Aberdeen has been increased to a more generous level than obtains in the other Scottish cities and in view of the fact that the health statistics of Aberdeen have for several years been appreciably better than those of the other cities) is a comparison of the costs of the Health and Welfare Services in the various cities. The nett rating expenditure per thousand of population was as follows in respect of Health and Welfare Services in 1955-56:—

HEALTH
SERVICES
COST LESS
IN ABERDEEN.

Dundee	£1,044
Glasgow	910
Aberdeen	833
Edinburgh	732

Edinburgh, with a smaller proportion of its population in Social Class V than any other city, and also a small proportion in Social Class IV (only 25·29 per cent. of adult males in these two classes combined, as contrasted with 32·92 per cent. for Aberdeen, 32·88 per cent. for Glasgow, and a slightly higher figure for Dundee) and with the lowest overcrowding figure of any of the cities, can perhaps manage with a less generous standard of services than Aberdeen; but at first glance **it appears remarkable that Aberdeen should be spending relatively less on its Health and Welfare Services than Dundee or Glasgow and yet securing better results.**

THE
EXPLANATION.

The explanation is fairly simple. Health and Welfare Services can in general be divided into (a) disease-preventing or health-promoting services, and (b) services for the treatment or palliation of diseased conditions. Broadly, the work of the health visitors, most of the work of the public health medical officers and of midwives, and some portions of the work of sanitary inspectors fall into the first category; on the other hand, district nurses, dental officers, home helps, the staffs of nurseries, the staffs of old people's homes, &c., are mainly engaged in tasks connected with treatment or palliation. (For example, a health visitor advising an old person about the dangers of a badly lit stair is clearly engaged in the prevention of accidents, whereas a district nurse and a home help come into the picture when the individual is partially disabled as a result of an accident; and a medical officer advising a woman about a marital difficulty is attempting to prevent a neurotic illness or to prevent the breaking of a family, whereas the day nursery staff become involved when the woman goes to hospital or when she leaves her husband). **In Aberdeen the emphasis on the preventive angle and the increase of the preventive staff have (in addition to reducing demands on the hospitals) reduced the need for the treatment services;** in places where less stress has been laid on prevention the rising mass of unprevented illness has necessitated a greater expenditure on services for treatment and palliation.

In other words, **the policy of the Aberdeen Health and Welfare Committee has paid dividends both in respect of improving health and in respect of keeping down expenditure.** It is a supreme tragedy that national neglect of the disease-preventing services—and in particular national reluctance to specify salaries and conditions of service attractive enough to make another two per cent. of trained nurses willing to transfer from hospital to public health work—should be in process of rendering the Committee's policy ineffective.

MISCELLANEOUS.

During the year an N.A.P.T. Travelling Scholarship was awarded to Miss **AWARDS.** M. M. Byrne, Health Visitor Tutor; a Nuffield Research Grant (for an investigation of home accidents) and a Medical Research Council Grant (for research in combined immunisation) were held by Dr. I. A. G. MacQueen; and just after the close of the year it was announced that Miss D. J. Lamont, Principal Health Visitor Tutor and Senior Health Guidance Lecturer, had won first prize in the Royal Society of Health Competition for an essay on "The advantages and disadvantages of amalgamation of Health Departments and Welfare Departments." Miss Lamont, who in 1955 was the first public health nurse in this country to hold the high award of a World Health Organisation Senior Travelling Fellowship, has again made history, since this is the first time that a Royal Society of Health prize has come to Scotland.

For the fourth consecutive year the Health Visitor Training School secured a hundred per cent. pass in the national examination for the health visitor's certificate.

During the year Dr. MacQueen had the double honour of being made a **POSTS HELD.** vice-president of the Women Public Health Officers' Association and a vice-president of the County Burgh Group of the Society of Medical Officers of Health; Dr. D. Younie, Senior Assistant Medical Officer, was President of the Scottish Child Health Group of the Society of Medical Officers of Health; Dr. I. A. G. MacQueen continued to hold the post of Honorary Secretary of the Scottish Branch of the Society of Medical Officers of Health; Mr. A. Hay, Chief Dental Officer, continued to serve as Honorary Secretary of the Public Health Group of the British Dental Association; Miss D. J. Lamont, Principal Health Visitor Tutor, was Chairman of an *ad hoc* Committee of the Scottish Health Visitors' Association for the preparation of evidence for the Working Party on Social Workers, and was appointed Chairman of a similar *ad hoc* Committee for preparation of evidence for the Maternity Services Review Committee; Dr. MacQueen served as a member of a Building Legislation Committee set up by the Secretary of State for Scotland; Miss M. M. Byrne, Health Visitor Tutor, was appointed Hon. Treasurer of the Scottish Health Visitors' Association; Dr. MacQueen was Chairman and Miss D. J. Lamont was a member of an *ad hoc* Committee set up by the Standing Conference of Representatives of Health

Visitor Training Centres to make recommendations on the staffing of training schools; Miss M. M. Byrne, Health Visitor Tutor, served as Honorary Secretary, Dr. MacQueen as Vice-President, and Dr. D. Barclay, Deputy Medical Officer of Health, as Chairman of the Care Sub-Committee of the Aberdeen Tuberculosis Care Committee; Dr. MacQueen served on the Executive Council of the Scottish Association for Mental Health, the Department of Health Consultative Committee of Medical Officers of Health, and the Scottish Public Health Committee of the British Medical Association; Miss D. J. Lamont was a member of the Area Nurse Training Committee; Dr. MacQueen served on the Board of Management of the Aberdeen Special Hospitals and on the Aberdeen Local Medical Committee; Mrs. M. Bell, Social Worker, and Dr. MacQueen served as directors of the Aberdeen Association of Social Service; and Miss Lamont and Dr. MacQueen were appointed members of a Regional Working Party on the elderly.

ADDRESSES TO NATIONAL CONFERENCES.

While 1956 does not approach 1954 for the number of addresses given to national conferences, &c. (in 1954, members of staff delivered eight separate addresses to national conferences as well as taking part in one television and two radio programmes), it was well ahead of 1955. In the course of the year Miss D. J. Lamont was invited to open a discussion at the Annual Conference of the Scottish Association for Mental Health (at Peebles) and to give a paper at the Annual Congress of the Royal Sanitary Association of Scotland (at Montrose); Miss M. Taylor, Research Health Visitor, was asked to address the Annual Conference of the Scottish Health Visitors' Association (at Greenock); and Dr. I. A. G. MacQueen was invited to address a special Conference convened by the Royal College of Nursing (at Edinburgh) and to take part in a radio programme on the care of the elderly.

PUBLICATIONS.

Published articles by members of staff during 1956 included—

- (1) "Staffing Standards for Health Visitors, District Nurses, and all-purpose Public Health Nurses," by Dr. I. A. G. MacQueen (*Public Health*).
- (2) "Future Trends in Preventive Medicine and Social Health," by Dr. I. A. G. MacQueen (*The Medical Press*).
- (3) "Food Poisoning due to Cl. Welshii," by Dr. J. Smith (Bacteriologist, Regional Hospital Board) and Dr. J. M. Wallace (*Health Bulletin of Department of Health for Scotland*).
- (4) "The Rôle of the Health Visitor in the Prevention of Mental and Emotional Disease," by Dr. I. A. G. MacQueen (*The Nursing Mirror*).
- (5) and (6) "Some Aspects of Public Health in Sweden" (two articles), by Miss D. J. Lamont (*The Nursing Times*).
- (7) "Some Comments on the Enquiry into Health Visiting," by Dr. N. Wattie (Glasgow) and Dr. I. A. G. MacQueen (*The Medical Officer*).

- (8) "Setting up a New Tuberculosis Care Committee," by Miss M. M. Byrne (*The Nursing Times*).
- (9) "Mental Health—Prevention of Disease," by Miss D. J. Lamont (*Proceedings of the Scottish Association for Mental Health*).

The writer thanks the Convener and members of the Health and Welfare **TRIBUTE**, Committee for continued interest, appreciation, and help; thanks officers of other Corporation departments and of other branches of the National Health Service for generous and frequent co-operation; and, in particular, offers very warm gratitude to his colleagues in the Health and Welfare Department—medical officers, dental officers, health visitors, midwives, sanitary inspectors, meat inspectors, welfare officers, clerks, staffs of nurseries and homes, &c.—who, despite staff shortages and inadequate accommodation, have seldom contented themselves with simply carrying out the work for which they were paid, but, of their own volition, have devoted much additional time and energy to a sustained effort to maintain the health and well-being of the people of Aberdeen.

I. A. G. MACQUEEN,
Medical Officer of Health.

HEALTH AND WELFARE DEPARTMENT,
WILLOWBANK HOUSE,
WILLOWBANK ROAD,
ABERDEEN.
28th March, 1957.

CITY OF ABERDEEN.

REPORT BY THE MEDICAL OFFICER OF HEALTH

For the year 1956.

1.—BACKGROUND DATA : DEMOGRAPHICAL, SOCIOLOGICAL, &c.

INTRODUCTION.

Any report on the health of a City during a year and on the work of its Health and Welfare Department in that year must consist largely of figures—death rates and sickness rates, numbers or percentages of persons examined, statistics relating to defects found on examination, numbers of persons attending clinics, numbers of visits paid by members of staff, and so forth. The various figures can sometimes be rendered more easily comprehensible by the use of suitable diagrams, but (whether expressed in tabular or pictorial form) they cannot convey really accurate information unless they are interpreted in the light of the social, economic, industrial, and climatic circumstances of the area to which they relate. A particular infant mortality rate might, for instance, reasonably be judged high and regarded as an indication of inadequate or inefficient child welfare services in a wealthy, well-housed community, while the same rate in another town with much overcrowding, poverty, and unemployment might properly be deemed low and regarded as indicating that the services were functioning satisfactorily.

As a prelude to the report it is therefore useful to set down some background data against which the health and welfare services can be studied. Apart from a brief pen-picture given in the next page or so, this chapter indicates demographical and socio-economic features on the same lines as in the report for 1955, except that the references to housing are mostly omitted in view of the inclusion, later in the report, of a special chapter on housing.

(1) *Some features of Aberdeen.*

The most northerly large town in the British Commonwealth, Aberdeen (population 187,000) is the third biggest city in Scotland and contains one twenty-seventh of the population of the country. A seaport with an extensive fishing fleet, Aberdeen is also the natural commercial and industrial centre for a considerable agricultural hinterland. Some of the main industries include—granite quarrying; manufacture of agricultural implements; fishing; shipbuilding; and manufacture of textiles, paper, woollen and flax materials. In summer the City, which has a bracing climate of the east coast type, is a very popular holiday resort.

Aberdeen is rich in educational and research institutions. Mention may be made of the University (formed in 1860 by the amalgamation of two universities which had existed for centuries within a mile of each other); the Marine Laboratory and

the Torry Research Station under the jurisdiction of the Department of Scientific and Industrial Research; the North of Scotland College of Agriculture and the Rowett Research Institute; the Macaulay Institute for Soil Research; a Social Medicine Research Unit of the Medical Research Council (attached to the Midwifery Department of the University); the Health Visitor Training School (attached to the Health and Welfare Department of the Corporation); the Dunfermline College of Physical Education (which trains all the women gymnastic teachers of Scotland); a College of Domestic Science, a Technical College, a College of Art, and a District Nurse Training School.

(2) *Social Stratification, Housing Conditions, &c.*

The density of population (16·4 persons per acre) is greater than that of Edinburgh or Dundee but less than that of Glasgow. Socio-economic classification of adult males shows that Aberdeen and Glasgow have considerably higher proportions in Social Class V (*i.e.*, unskilled workers) than have other Scottish cities or Scotland as a whole.

Despite a vigorous housing policy in recent years, there is still much overcrowding: at the last census 12·6 per cent. of the population were living more than two per room (as compared with 9·4 per cent. in Scotland and 2·0 per cent. in Britain as a whole), and Aberdeen was less favourably placed than any other Scottish city in respect of families lacking exclusive use of each of the following facilities—piped water supply, water-closets, kitchen sink, and cooking stove or range. In 1956 the list of applicants for Corporation houses comprised some 11,000 families (or roughly a fifth of the population of the City) of whom approximately 3,200 were sub-tenants, 4,800 were in unfit houses, and 3,000 were in overcrowded but fit houses.

(3) *Miscellaneous Points.*

- (a) Unemployment during the year was not very extensive: *e.g.*, 2,827 on 10th December, 1956, in the area covered by the Aberdeen Employment Exchange, as compared with 2,233 on 12th December, 1955.
- (b) The estimated population rose by 44 to 186,396.
- (c) The number of houses rose by 781 to 55,695.

GENERAL DATA.

Area of City.—After the extension of boundaries in 1952, the area (exclusive of inland water, tidal water, and foreshore) is 11,362 acres.

Population.—The 1951 census enumeration gave a total of 182,729, or, when corrected for normal residence, 183,247. The estimated population at the middle of 1955 was 186,352, and the estimated population at the middle of 1956 was 186,396.

Growth of the Population.—The growth of the City may be very roughly summarised as follows:—For many centuries Aberdeen had a population of under 15,000. During the 18th century it increased to 27,000. In the thirty years, 1801-1831, the population doubled. In the next sixty years it doubled again. By 1911, it had risen to 163,891. During the twenty years, 1911-1931, there was little growth; the population in 1931 was 167,258, representing an average annual increase of 168 over the period. During the twenty years, 1931-1951, the average annual increase in the population was 798 and, in the years since the last census, the estimated annual growth is of about that figure.

Density of Population.—On the latest estimate the density is 16·4 persons per acre.

Number of Houses.—The number in 1956 was 55,695, an increase of 781 on the total in the previous year. The distribution of houses in the various Wards was as follows:—

Ward.	No. of Houses.	Ward.	No. of Houses.
No. 1—St. Clement's . .	4,283	No. 7—Rosemount . .	3,631
No. 2—St. Nicholas . .	5,263	No. 8—Rubislaw . .	3,814
No. 3—St. Andrew's . .	4,469	No. 9—Holburn . .	4,425
No. 4—St. Machar . .	3,909	No. 10—Ruthrieston . .	4,547
No. 5—Woodside . .	4,813	No. 11—Ferryhill . .	4,531
No. 6—Cairncry . .	7,735	No. 12—Torry . .	4,275

Average Number of Persons per House.—In the Annual Report for 1952, there were given the census figures for the four cities. The figure for Aberdeen was 3·48; and the latest estimated figure, based on the Registrar-General's estimate of the population (186,396) for the middle of 1956, and the City Assessor's return as to the number of houses in the City, is 3·35.

Rateable Value (1955-56)—£2,294,708.

Population—Age Distribution.—The following table indicates the proportions of the population in various age-groups at census in 1911, 1921, 1931, and 1951:—

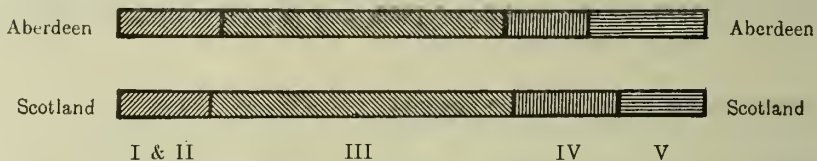
	Under 1 year.	1 and under 5 yrs.	5 and under 15 yrs.	15 and under 25 yrs.	25 and under 45 yrs.	45 and under 65 yrs.	65 yrs. and upwards.
1911 . .	2·23	9·03	22·13	19·13	26·84	15·31	5·33
1921 . .	2·35	6·66	19·41	20·00	27·00	18·42	6·16
1931 . .	1·75	6·81	17·22	18·65	28·51	19·81	7·25
1951 . .	1·63	7·44	14·14	14·76	28·84	23·21	9·98

Population—Marital Condition.—The outstanding change revealed by a comparison with twenty years ago is that a far higher proportion of men and women aged 20-30 years are married. There is also a slight increase in the proportion of widows (but not of widowers), and a rise in the number of divorced persons (to nearly 1 per 200 population).

Social Class Distribution of Adult Males.—A convenient socio-economic classification is that adopted by the Registrar-General who divides adult males according to occupation into five social classes. Class I includes such categories as shipowners, company directors, architects, journalists, medical practitioners, solicitors, &c.; Class II contains farmers, farm managers, shopkeepers, nurses, teachers, police inspectors, &c.; Class III, the biggest group, consists mainly of skilled artists and foremen—market gardeners and market gardening foremen, blacksmiths, shipwrights, plumbers, bus drivers, shorthand typists, postmen, &c.; Class IV is mainly semi-skilled workers—railway ticket collectors, paint sprayers, fishermen, bus conductors, barmen, hospital orderlies, &c.; and Class V includes unskilled workers—agricultural labourers, dock labourers, lift attendants, newspaper sellers, hawkers, &c. Exact figures based on the census enumeration have not been published, but the following percentages, calculated from the gross figures given in the Registrar-General's One per Cent. Sample Tables (H.M. Stationery Office, 1952), give, with a fairly small margin of error, comparative data for the four cities and for Scotland as a whole, while the diagram depicts the proportions in Aberdeen and in the country:—

PERCENTAGE OF EACH SOCIAL CLASS.					
	I.	II.	III.	IV.	V.
Scotland . . .	2·96	13·21	50·92	18·21	14·71
Aberdeen . . .	3·65	14·12	48·84	14·12	19·27
Dundee . . .	2·03	9·98	51·62	18·45	17·93
Edinburgh . . .	5·36	12·71	56·65	10·79	14·50
Glasgow . . .	2·07	10·17	54·88	13·60	19·28

Proportions in Social Classes.



Some important points that emerge from a study of the above figures are—

- (1) The percentage of persons in the lowest social class is practically identical in Aberdeen and Glasgow, being much higher than in any other city and very much higher than in Scotland as a whole. It may also be mentioned that the percentage of persons in Class V is appreciably higher in Aberdeen than in most English cities.
- (2) The proportion of persons in Classes IV and V taken together is greater in Aberdeen than in Glasgow.
- (3) Aberdeen has a smaller percentage of persons in Class III than any other Scottish city.
- (4) Aberdeen has a higher proportion of inhabitants in Class I than any city except Edinburgh.

Unemployment.—Unemployment during most of 1956 was not very extensive, though a shade more than in the previous year. At the latest date for which information is easily available (10th December, 1956) the numbers of unemployed persons in the area covered by the Aberdeen Employment Exchange were—

Men, 2,197; Boys, 26; Women, 589; Girls, 15; Total, 2,827.

Occupations.—As in previous years, it has not proved possible to provide an exact analysis of the gainfully employed members of the community in respect of occupation.

The Aberdeen Employment Exchange serves Aberdeen City and an adjacent county area (Bucksburn, Dyce, and Cults) with a population of approximately 15,000. According to the Ministry of Labour and National Service, the main occupations in the area served by this Exchange are—

Agriculture and Horticulture.	Food and Drink: Grain Milling.
Fishing.	Bread and Biscuit Making.
Stone Quarrying.	Meat Products.
Cast Concrete and Monumental Masonry.	Milk Products.
Chemicals and Allied Trades.	Fish Curing.
Engineering, Shipbuilding, and Electrical Goods.	Aerated Water Manufacture.
Motor Body Building and Motor Repairing (Garages)	Wooden Container and Basket Manufacture.
Metal Goods not elsewhere specified.	Paper and Printing.
Woollen and Worsted Manufacture.	Horn Comh and Plastics Moulding.
Flax Manufacturers.	Building and Contracting.
Net Making and Braiding.	Gas, Electricity, and Water Services.
Hosiery and Other Knitted Goods.	Transport and Communication Services.
Clothing: Tailoring.	Distribution Trades.
Dressmaking.	Insurance, Banking, and Finance.
Shirtmaking.	Public Administration and Defence.
Boot and Shoe Repairing.	Professional Services.
Sawmilling.	Entertainment and Sport.
Furniture and Upholstery.	Catering—Hotels, &c.
	Laundry and Dry Cleaning.
	Hairdressing.

Meteorological Data.

Temperature.—The lowest temperature registered during the year was 15°F (in the week ended 4th February). In the previous year, the lowest temperature recorded was 14°F, and in 1954 the lowest was 17°F.

The highest temperature registered was 76°F (during the week ended 28th July). The highest temperature recorded during the previous year was 79°F, and in 1954 the highest was 73°F.

The diagram on page 6 gives the maximum and minimum temperatures during each week of the year.

Rainfall.—The total rainfall during the year (at Craibstone, just outside the City) was 33.73 inches, as compared with 28.10 inches in 1955, and 35.12 inches in

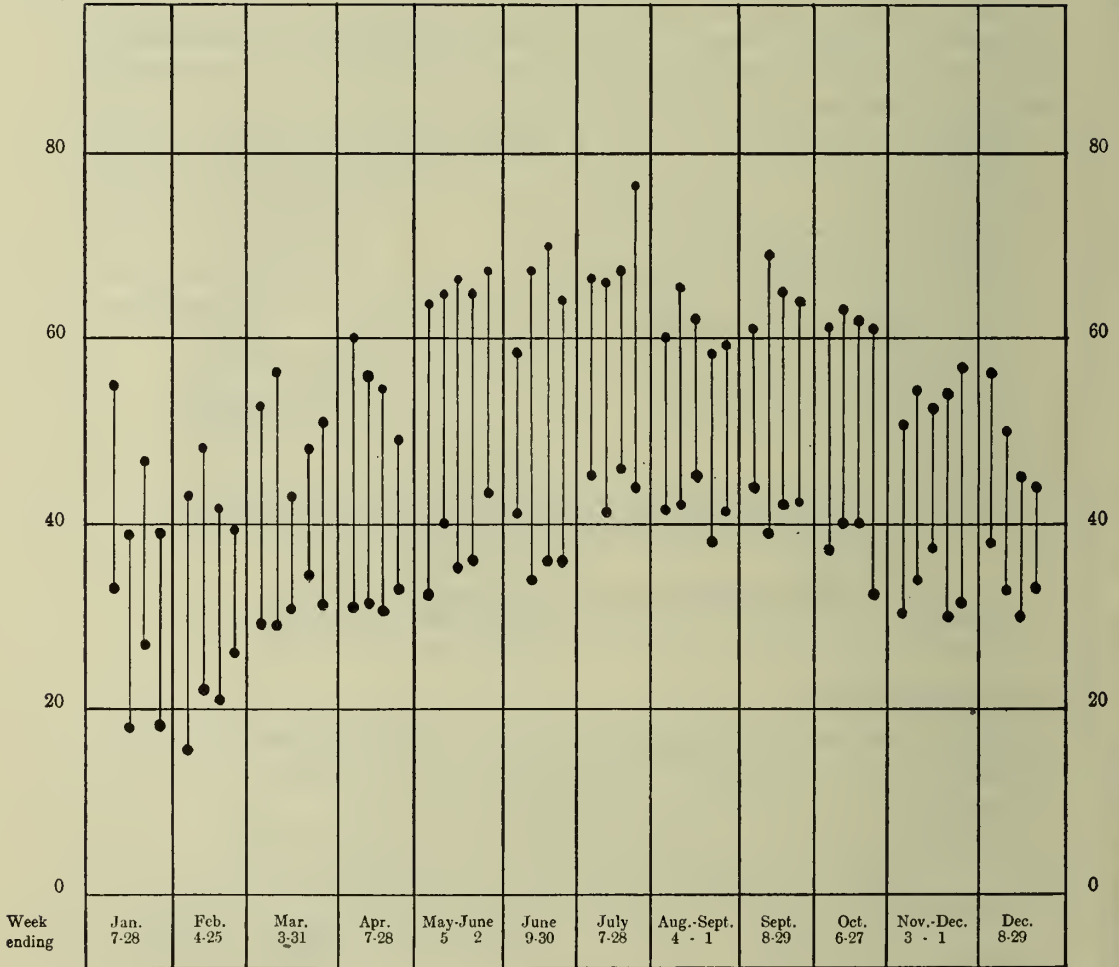
CITY OF ABERDEEN.

TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA
° FAHR.

° Fahr.

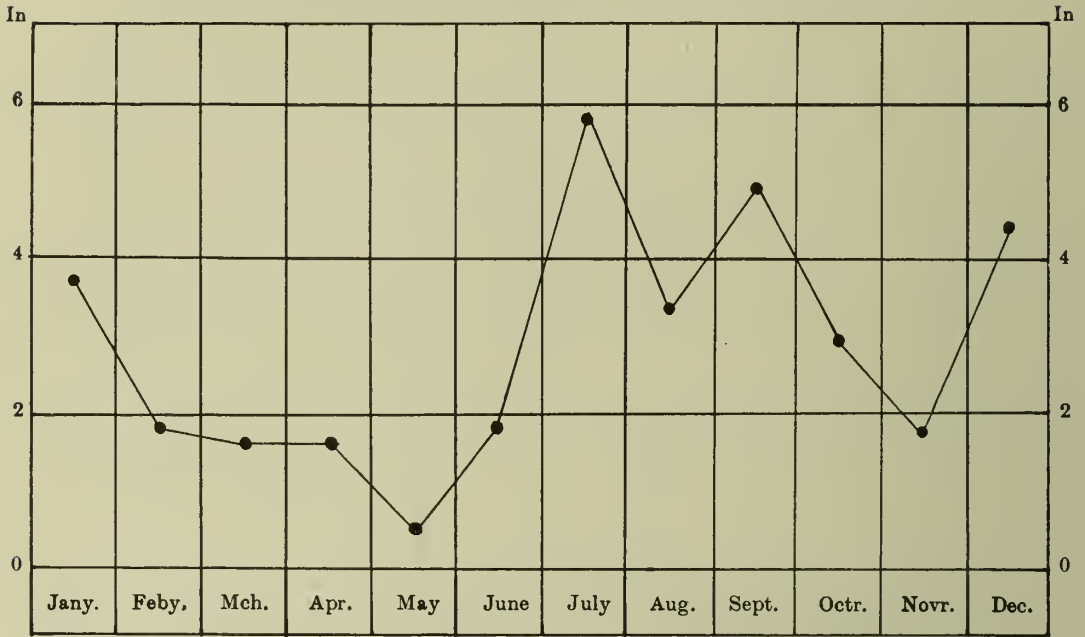
YEAR, 1956.

° Fahr.

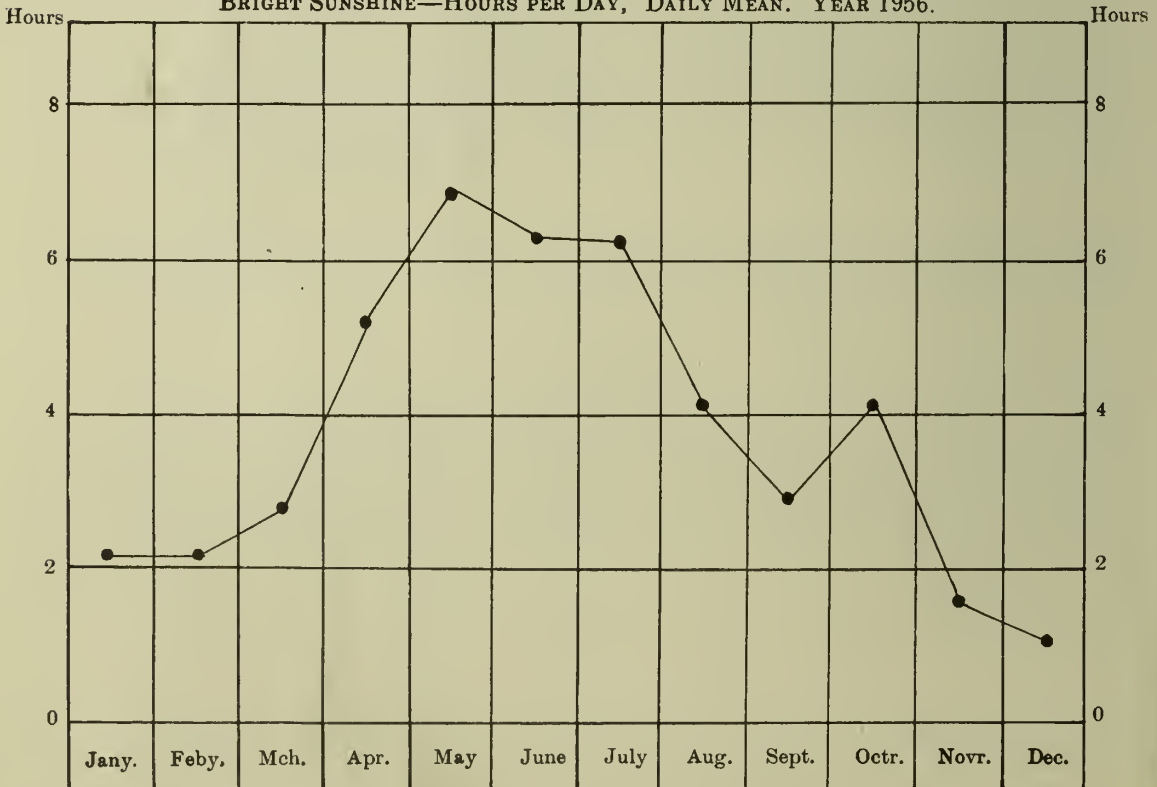


CITY OF ABERDEEN.

TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION. YEAR 1956.



BRIGHT SUNSHINE—HOURS PER DAY, DAILY MEAN. YEAR 1956.



1954. The distribution of rainfall in the different months is shown in diagrammatic form.

Sunshine.—The average daily hours of sunshine during each month are shown in the diagram.

Wind.—The average wind velocity during each month is shown in the following tables:—

WIND VELOCITIES AND DIRECTIONS.

From three-hourly readings at the Meteorological Office of Dyce Airport, the number of gusts of varying velocities in each month was as follows:—

	Number of Gusts at various speeds (in knots).				
	Over 33.	22-33.	11-21.	1-10.	Calm.
January	1	18	97	87	45
February	0	6	50	122	54
March	0	13	109	104	22
April	0	1	60	130	49
May	0	15	105	106	22
June	0	6	83	113	38
July	0	5	62	132	49
August	0	1	45	159	43
September	0	1	36	163	40
October	0	10	98	102	38
November	0	21	107	75	37
December	2	30	100	74	42

The directions of the various gusts in each month were—

Month.	Number of Gusts from							
	North.	N-E.	East.	S-E.	South.	S-W.	West.	N-W.
January	17	0	4	23	33	34	55	37
February	40	10	16	8	19	9	33	43
March	16	3	13	85	60	5	33	11
April	43	7	10	20	34	18	17	42
May	12	5	8	19	61	41	46	34
June	32	4	9	22	41	11	29	54
July	31	11	39	23	33	14	14	34
August	56	9	16	18	34	4	16	52
September	18	14	16	20	72	20	12	28
October	24	1	4	9	39	39	51	43
November	7	0	0	13	57	17	49	60
December	2	0	1	51	73	47	29	3

2.—SOCIAL PROBLEMS ASSOCIATED WITH HOUSING.

(The substance of this chapter was submitted as a Special Report in May, 1956.)

Since shelter, security, and comfort are among the basic things in the life of a family or an individual, it is not surprising that questions of housing are involved in the consideration of nearly every social problem affecting a family or an individual. A full and comprehensive report would therefore be an enormous document and would include the bulk of the activities of the staff of the Health and Welfare Department.

The report here presented does not pretend to be comprehensive but merely attempts to pick out some of the types of social problem in which housing plays an important part; even so, the report is inevitably a very long one.

It is perhaps convenient to think in terms of nine groups—

- I. Families needing a house but not yet having one;
- II. Families who have had a house but who have become deprived of it;
- III. Families living in overcrowded houses;
- IV. Families living in unfit houses;
- V. Families who have transferred to better houses;
- VI. Families seeking to transfer back to unfit houses;
- VII. Physically handicapped persons;
- VIII. Persons occupying houses which they no longer need; and
- IX. Problem families.

I. FAMILIES REQUIRING HOUSES BUT NOT YET OCCUPYING HOUSES.

These are in most cases young married couples living with in-laws, or young married couples in rented furnished rooms. (The total number of such families exceeds 3,300.)

(A) Problems Liable to Arise.

A mass of problems arise through lack of privacy, lack of comfort, and lack of security of tenure. For example—

- (1) Where a young couple are living with the wife's mother or (as less frequently happens) with the husband's mother, there may be bickering as a result of the different outlooks of the different generations.
- (2) The young married woman does not have a chance to learn how to stand domestically on her own feet before she has a family. She relies on her mother's advice and guidance and then finally has to become an independent housewife, starting to run a home of her own for the first time when she has the extra burden of a young child.

- (3) As a result of the lack of privacy or as a result of the bickering that may take place, the husband not infrequently finds the public-house a useful place of refuge. Seeds of marital disharmony are laid and before the young couple have a home of their own at all the genesis of a broken home may be present.
- (4) After a child has been born there may be friction with the older generation over the rearing of the child.
- (5) Where the young couple are in a rented room after a child has been born there may be problems concerned with the development of the child, *e.g.*, the sub-tenants may feel it necessary at all costs to prevent the child crying lest they annoy the landlord and are turned out. Similarly, at a later stage, they may curb the toddler's activities for fear that noise will disturb the landlord.
- (6) There are, of course, the problems of sheer overcrowding as the young couple, whether residing with relatives or occupying rooms as a sub-tenant, expand their family.

(B) Existing Sources of Help.

No real permanent solution of these problems is possible until such time as a house becomes available. A considerable amount of help and guidance, however, can often be given by the district health visitor who visits the household frequently from the time that the mother first appears at an ante-natal clinic. Much useful advice (*e.g.*, on the need for mutual toleration by the different generations and on methods of avoiding friction) can be tactfully presented and, where necessary, other services can be brought in as required, *e.g.*, the sub-tenants whose family is expanding too fast for their present accommodation can be referred to the Family Planning Clinic, and the young couple whose marriage is showing signs of breaking under the strain can be referred to the Marriage Guidance Council.

(C) The Rôle of the District Health Visitor.

The Royal Society of Health has designated the health visitor "the spearhead of the social services," and she has been described as "the person to whom a housewife can turn for advice on family budgeting, household economics, dietetics, personal hygiene, and matters relating to the physical and emotional health of all members of the family."

The family health visitor is increasingly functioning as the general purpose social worker for her district (and her post-qualification training for the Health Visitor's Certificate is, of course, designed to equip her for this work). To make the position clear it is perhaps desirable to quote a paragraph from the Annual Health Report for 1955—

"Health Visitors as General Purpose Social Workers."

To enable the health visitor to get to know her families more closely and to avoid having too many social workers visiting the same homes, the health visitors attends the school in her area as school nurse, and visits school children at home where necessary as well as expectant mothers and pre-school children; she also visits elderly people in her area; and to a large extent she acts also as social welfare visitor. It is intended that, ultimately, health visitors should also be responsible for the health and social welfare of cripples and handicapped persons in their area, although at present—while schemes are still in process of development—a specialist health visitor and a social worker are engaged on the visiting of physically-handicapped persons."

(D) Gaps in the Help Provided.

(1) From a housing point of view the great need is more houses. Until a house is available for any couple as soon as they marry, problems of the types indicated above will continue to arise.

(2) Advisory and guiding services are incomplete in two respects—

Firstly, the visits of the health visitor normally begin during the first pregnancy. Before that, a young couple living with relatives or in furnished lodgings receive no advice unless they have the initiative to seek it. (There is probably no easy solution to this difficulty. The impending arrival of the first baby makes it easy for the health visitor to seek access to the parents and thereafter to advise on a multitude of problems; but it would be much more difficult for either the health visitor or any other social worker to gain admission at an earlier stage. Nevertheless, if there were sufficient health visitors, it might be worthwhile for them to visit each couple a month or so after the marriage and to continue visiting where the couple so desired.)

Secondly, there is an alarming shortage of health visitors: at 30th April, 1956, there were 24 vacant posts on the interim establishment of 85. There is no point in thinking of appointing social science graduates as substitutes, since they are in equally short supply. These shortages (which have already been the subject of a special report to the Corporation) are unlikely to be remedied until such time as salaries and promotion prospects are substantially improved on a national basis. To put it bluntly, a woman is not going to spend $4\frac{1}{2}$ years in full-time training to become a health visitor (or nearly as long in full-time training to obtain a social science degree and diploma) if she can actually earn more by spending 3 years in training as a primary school teacher or by taking the still shorter training required for a driving test examiner, or if she can earn more than twice as much by spending five years (or a few months longer than the health visitor's training period) in taking a training in dentistry.

II. PERSONS WHO HAVE HAD HOUSES BUT HAVE BECOME DEPRIVED OF THEM.

(A) Immediate Problems and their Solution.

Acute immediate problems arise in the case of persons deprived of their accommodation by fire or flood, or of persons evicted for non-payment of rent. The immediate problems are related to finding accommodation forthwith. These problems are normally dealt with by the Senior Assistant Welfare Officer of the Health and Welfare Department, and since they are usually solved they will not be further discussed here. It may, however, be useful to mention that, in 1955, 22 such families were temporarily housed by the Health and Welfare Department, while the services and advice of the department were made available to a further 274 such families. No person is left without some form of immediate shelter.

(B) Less Immediate Problems.

Many long-term problems arise in such cases but these are essentially little different from the problems arising in other groups.

III. and IV. PERSONS LIVING IN OVERCROWDED OR UNFIT HOUSES.

(There are 4,980 families occupying houses already listed as unfit, and at least another 3,000 families occupying overcrowded houses that are not listed as unfit. Most of the latter are on the Corporation's housing waiting list, but a few are not on the list.)

(A) Problems Liable to Arise.

(1) *Problems related to health.*

Overcrowded houses and unfit houses play important parts in at least six main groups of diseases—

- (a) Pulmonary tuberculosis;
- (b) Chronic respiratory infections;
- (c) Diseases of the heart and circulation;
- (d) Disabling conditions affecting locomotion, *e.g.*, spinal diseases, disseminated sclerosis, poliomyelitis, epilepsy;
- (e) Diseases of the special senses, *e.g.*, blindness; and
- (f) Psychiatric conditions.

Obviously the different groups of diseases are differently affected by different types of defect. For example, a person already suffering from (or predisposed to) infection of the respiratory tract will be much more harmed by a smoky chimney than will a person suffering from osteo-arthritis who is, however, badly affected by having to tackle stairs.

Under this heading, one has always to consider whether re-housing will facilitate recovery, whether re-housing will facilitate better nursing attention, and

whether re-housing will prevent the spread of infection, as well as whether housing conditions are actually a cause of the ill-health. Apart from these six main groups of diseases, housing factors play quite important parts in a mass of other diseases. For example, officers of the Health and Welfare Department of Aberdeen demonstrated fairly recently that there was a significant correlation between overcrowding and the development of squint. Again, current research in the Health and Welfare Department suggests that housing conditions play a very considerable part in the causation of home accidents: various types of accident in the home have a significant association with overcrowding, while certain types of accident have associations with certain types of house defects.

Housing and health are in fact constantly interlocked. Indeed, one of Britain's leading public health experts has recently devoted an entire book to the relationship between the dwelling and the health of the family, and to the health functions of the home. It is worth while to point out that the psychological dangers of overcrowded, squalid houses are perhaps even greater than the physical dangers; slum life breeds strife between the parents, poisons the wells of family life, drives the children to the streets, increases juvenile delinquency, and profoundly damages the personality of each member of the family. It is probably also worth while to mention that the seriously unfit house by itself constitutes a much greater danger to health than the seriously overcrowded house by itself, although, of course, the worst offender is the unfit, overcrowded house.

(2) *Other Problems.*

Quite apart from the health aspects, prolonged occupation of a damp, badly ventilated, dilapidated dwelling or of a gravely overcrowded house tends to cause a gradual loss of spirit and a slow degeneration of morale. Not all families in sub-standard houses succumb to the tendency to lower their standards: many contrive to keep the house clean (despite the smoke from the living-room fire and the plaster falling from the ceiling), to keep the children clean (despite the absence of a supply of hot water), to serve well-cooked meals (despite the inadequacy of cooking facilities and the lack of storage), to ensure that the children get sufficient sleep (despite the blaring wireless in the flat below), and generally to resist their surroundings. Such resistance, however, is difficult and may become impossible if the adverse environmental factors are reinforced by other adverse factors. Some examples may be illustrative:—

- (a) Combination of bad housing and ill-health. A family may be capable of resisting bad housing alone or maternal illness alone, but deteriorate rapidly when the two factors are simultaneously present.
- (b) Combination of bad housing and poverty. A family may successfully withstand unsatisfactory housing, but incur certain additional expenses in so doing: *e.g.*, they compensate for dampness by spending more on fuel and for lack of larder accommodation by purchasing food in small quantities at slightly greater cost. When the breadwinner becomes

temporarily unemployed, they are no longer able to incur such additional expenses.

In connection with the combination of bad housing and poverty, it may be useful to refer to the "affluence-poverty curve" of the normal worker. He is relatively well off as a young man (unmarried and probably living at home), less well off after marriage, impoverished when his children are dependent (despite the partial help of family allowances), affluent again when the children become self-supporting, and impecunious when he retires from work.

- (c) Combination of bad housing and large family. A housewife who has coped successfully with two children in a sub-standard house may fail completely after the third or fourth child is born.
- (d) Combination of bad housing and poor mental capacity. A couple who are not intellectually well endowed may be capable of managing in a fit house, but incapable of surmounting the additional difficulties of life in a squalid slum.

The degeneration of morale may manifest itself in many ways—*e.g.*, uncleanness, child neglect, marital disharmony, breaking of the family, alcoholism, &c. These, however, are not the problems (though each has to be tackled) but merely symptoms of the problem.

Even when morale is maintained, problems abound—*e.g.*, the senior school child in the overcrowded house lacks privacy for study, the younger child's development is thwarted by lack of facilities for play; and the housewife (striving to keep a "difficult" house clean) becomes virtually housebound with no time or energy for leisure activities.

(B) Existing Sources of Help.

Apart from the all-important matter of the provision of a suitable house (when possible), help has to be directed both to the improvement of environmental conditions and to the prevention or removal of other adverse factors. Some sources of help are as follows:—

- (1) The advice of the sanitary inspectors of the Health and Welfare Department is constantly available on environmental factors. Where a particular housing defect can reasonably be rectified, the department takes all necessary steps to secure such rectification.
- (2) With a view to the allocation of medical points towards a new house, health aspects are assessed by a medical officer—a heart-breaking task since nearly every housing applicant offering medical evidence in his support is in genuine need of re-housing on health grounds but only a fraction can be given sufficient points to ensure re-housing.
- (3) To advise on household budgeting (particularly important where bad housing conditions are aggravated by financial stringency), storage of

food, preparation of meals (often with poor cooking facilities), cleanliness, hygiene, and matters of physical and emotional health, the family health visitor is constantly available. In particular, she visits most households containing an expectant mother and almost every household containing a young child; and she visits frequently.

- (4) At the request of the family health visitor or, in cases of illness, of the family doctor, other sources of help may be utilised—*e.g.*, where the mother is showing signs of over-fatigue, she may be given temporary relief by a young child being accommodated for a few weeks in the residential nursery or by an older child being admitted to Linn Moor Convalescent Home for a spell; where there is illness, the services of a home help may be made available; where marital difficulties are apparent, the couple may be referred to the Marriage Guidance Council; and so on.
- (5) Where a highly unsatisfactory situation has developed, remedial services are available. Thus, a deserted child will be taken into care by the Children's Committee, and a seriously maladjusted child will be treated at the Child Guidance Clinic. (Without in any way minimising the importance of these services, it is desirable to stress that they are services designed to cope with failure, whereas the aim of the services outlined in the previous four paragraphs is to prevent that failure in as many cases as possible.)

(C) Gaps in the Help Provided.

Consideration is here limited to *ordinary* people in overcrowded or unfit houses. (Problem families, the elderly, and the physically handicapped are discussed later.)

- (1) There is, of course, still a grave lack of new houses. At the 1951 census more than one person in every eight in the City was living under seriously overcrowded conditions (at more than two persons per room), and Aberdeen was less favourably placed than each of the other main cities in respect of the proportion of families lacking the sole use of a water-closet, a cooking stove or range, a kitchen sink, and a piped water supply.
- (2) Apart from the alarming shortage of health visitors (mentioned previously), there do not appear to be many serious gaps in the help and guidance available, although it is not unlikely that a further expansion of the home-help service may have to be considered in the fairly near future.

It may be argued that, while the family health visitor visits 99 per cent. of houses containing young children, many houses containing school children, and an increasing proportion of houses containing old people, there is a considerable gap: the youngest child may leave

school when the parents are aged 45. It should be remembered, however, that

- (a) certain special groups (the physically handicapped and the problem family) are considered separately;
- (b) the "affluence-poverty curve" (already mentioned) is such that the couple whose children are no longer dependent are usually financially better off than before and are therefore in less need of advice about such things as household budgeting;
- (c) by the time the children leave school, the mother has had many years of experience in housekeeping and is the less likely to require guidance;
- (d) if a couple managed to surmount the difficulties occasioned by an unfit house when they had the additional strain of coping with young children, they are likely to manage satisfactorily after the children are off their hands; and
- (e) the dominant combination of factors leading to household failure in the period between the end of dependency of children and the retirement of the wage-earner is bad housing and illness, and the development of after-care services (when the existing shortage of health visitors is overcome) should be of material benefit here.

There is, however, a minor gap—persons without dependent children and not yet elderly, living under bad housing conditions, and becoming unemployed for prolonged periods. Such persons are not at present very numerous: at a recent date the total number of unemployed adult males in the area of the Aberdeen Employment Exchange was 1,629, of whom the overwhelming majority were only temporarily out of work. Nevertheless, the long-term unemployed (whether in sub-standard houses or not) could benefit from the advice of a health visitor (or of any other adequately trained social worker) on such matters as wise expenditure of very limited money, obtaining of any additional allowances or services appropriate, maintenance of morale, &c. It may be worth while to mention that, in a recent piece of medico-social research in Aberdeen that involved special visits by a health visitor to a number of unemployed workers, the health visitor was welcomed in almost every case. However, there is a severe shortage both of health visitors and of social science graduates, and the use of inadequately trained persons might well do more harm than good. Moreover, one should not forget the existence of a voluntary body, the Association of Social Service, which to some extent tackles these problems.

V. FAMILIES TRANSFERRED TO BETTER HOUSES.

(The number may be regarded as anything from 1,000 to 4,000, according to the time deemed to be required for a family to become accustomed to the new environment.)

(A) Problems Liable to Arise.

While the general effects of re-housing are unquestionably good, health visitors and other social workers often state, largely rightly, that they find even more social problems affecting people transferred to better houses than in the case of persons still residing in slum property.

- (1) The economic aspects are particularly important. As Dr. M'Gonigle, when Medical Officer of Stockton, showed, mortality and morbidity are often greater in re-housed families than in similar families not yet re-housed, because better housing may have been achieved at the cost of a reduction in the money available for food. The type of financial problem that arises in connection with a re-housed family is that the father may have to spend 10d. a day on bus fares, that the mother may have an 8d. fare when she goes into the centre of the town for shopping, and that, if the family wish to visit a cinema, they may have an extra 2s. 6d. on bus fares. The rent is higher. The cost of fuel is greater. There is less money available for food, clothing, and recreation. To some extent, the advice of health visitors and other social workers on family budgeting can reduce these problems.
- (2) Again, the family who have been re-housed in a new district are removed from their previous social life. The housewife in particular is sometimes pathetically lonely, and in moments of difficulty she lacks the wise neighbour to whom she formerly turned for advice. Problems arise in connection with fitting these people into their new environment. The development of community centres and of peripheral child welfare clinics has probably been useful here, but, in connection with community centres, it has to be remembered that, where there are young children, the parents often cannot both get out together even once in the week.
- (3) Problems arise in connection with the new house and garden. The man who has previously lived in a tenement may have little idea of how to deal with a garden. The housewife may be alarmed by unfamiliar cooking and heating devices.
- (4) The children, transferred from their former home and school, may at first be unhappy in their new surroundings. In general, pre-school and younger school children adapt quickly to their new environment; older school children and adolescents may be unhappy for a considerable time.

- (5) Although the statement may seem paradoxical, playing spaces are often more limited in new housing areas on the periphery than in the centre of the city.
- (6) Artificial overcrowding is common. A family who require a four-apartment house and who have been allocated such a house will not infrequently in effect occupy only three apartments so as to have a "best room" that is always tidy for the reception of visitors. Thus, because of tradition or because of a desire for display, the evils of overcrowding remain although the family are technically not overcrowded.
- (7) Actual overcrowding is quite common. Families, faced with higher rents, &c., solve their financial problems by sub-letting rooms.
- (8) In some areas the allocation of the majority of the houses to parents with young children leads to the creation of a community of unbalanced age structure. Mastrick, for example, to-day needs a disproportionate amount of child welfare clinic facilities or an excessive number of places in infant schools; and in seven or eight years these, if provided, will be half-empty, while there will be a high demand for places in junior secondary schools, which again will be half-empty five or six years later.
- (9) In some cases re-housed families solve their financial problems by the mother taking a job—with possible detrimental effects on young children.

(B) Existing Sources of Help.

The family health visitor can (in addition to advising about health maintenance) contribute considerably to the alleviation of loneliness, the maintenance of morale, the wise expenditure of the housekeeping money, &c.

The community centre, the youth club, the child welfare clinic, the school, and the local church all play useful parts. The friendly neighbour can be invaluable.

(C) Gaps in the Help Provided.

(1) The existing grave shortage of health visitors is a very serious factor in re-housing districts. Where a health visitor already knows most of her families well (*e.g.*, in a district where the population is relatively stationary), she can probably cope reasonably well with a total population of 2,500, and can sometimes even manage with a total population of 3,000; but in a district consisting largely of new houses, where the health visitor has to get to know most of the families, she cannot hope to serve satisfactorily a population of much over 2,000. (The Society of Medical Officers of Health and the Deputy Chief Medical Officer of the Department of Health for Scotland have each stated that the maximum case-load for a health visitor should be 2,500 total population, and more than one writer has argued

in favour of a case-load of 2,100 or 2,200. The Corporation's authorised establishment of 85 health visitors works out—discounting 11 on special duties such as tuberculosis work—at almost exactly 2,500 population for each health visitor; but the present staff of 61—including 11 on special duties—is equivalent to a case-load of over 3,500 population for each health visitor.) The Corporation has tried to meet the grave shortage by sanctioning the temporary appointment of four nurses without the health visitor's certificate, but there is, of course, a limit to the extent to which less highly trained officers can replace persons with specialist training.

(2) Inevitably the development of community centres and clinics tends to follow the erection of houses: when the first people are re-housed in a new housing scheme there is no clinic for them, although to a considerable extent the use of the Corporation's mobile clinic fills the gap. Sometimes, however, as in Northfield and Mastrick at present, the population becomes too large for the mobile clinic before a permanent clinic is available.

(3) As mentioned in paragraph (8) above, the allocation of the bulk of the houses to families with children aged 0-7 years creates a curious community problem; either clinics and classrooms must be provided in the knowledge that some of them will become redundant in due course, or the district must for some years endure overcrowded clinics and schools.

(4) The development of a sitter-in service to enable parents with young children or couples with infirm elderly relatives to have an occasional evening out together would be a great boon.

VI. FAMILIES SEEKING TO TRANSFER BACK TO UNFIT HOUSES.

The main problems leading families to seek to return to unsatisfactory houses are—

- (1) Financial (by far the most frequent).
- (2) Loneliness and failure to "fit in" to the new community.

Both points have been considered under V.

VII. CRIPPLES AND OTHER PHYSICALLY HANDICAPPED PERSONS.

(A) Problems Liable to Arise.

Handicapped persons are liable to all the problems affecting the rest of the community, and also to special problems in respect of (1) finance; (2) unemployment; and (3) living conditions. The financial and employment aspects are fairly obvious: these unfortunate people have usually only enough money to buy the bare necessities of life, little prospect of employment, and a sense of uselessness. It may be worth while to mention living conditions. Of the 319 handicapped persons at present on the Health and Welfare Department's register (*i.e.*, persons handicapped otherwise than by blindness or deafness), 53 are housewives, and of these 53 no fewer than

20 live in upper flats. Many of them have considerable difficulty in negotiating stairs.

(B) Existing Sources of Help.

(1) *Provision of Employment.*—For some of those able to work the Remploy Factory is useful, but it is not large and cannot expand.

(2) *Provision of Occupation for those not employed.*—The Corporation has approved in principle of the provision of an occupation centre; efforts are being made to secure suitable accommodation.

(3) *Advice about Social Problems, Suitable Appliances, &c.*—A health visitor and a social science graduate devote the whole of their time to the well-being of the physically handicapped, and a medical officer (with previous experience as a Medical Officer of the Ministry of Labour and as a registrar in a physical medicine unit) devotes part of his time to the subject.

(C) Gaps in the Help Provided.

The main gap is the lack of suitable ground floor accommodation.

VIII. PERSONS OCCUPYING HOUSES WHICH THEY NO LONGER NEED.

(A) Problems Liable to Arise.

(1) Frequently elderly people occupy houses too large for them, *e.g.*, a couple who needed a five-roomed house when their children were young continue to occupy the house after all the children have left home. As energy and capacity for house-work decline with advancing years, the old couple find the large house more and more of a burden. Possible solutions include—

(a) Transfer to a small house—but often the old people feel that this is a social degradation.

(b) Giving up the house and living with younger relatives—but there is a profound difference between being master of one's own house and being a virtual dependent in the house of a son or daughter.

(c) Admission to an old people's home—but often elderly citizens feel that this involves giving up their independence.

(2) As occupation ends and contemporaries die many old people suffer from intense loneliness, from lack of interests and hobbies, and from a feeling that they are of no further use in the world.

(3) Many are afflicted by needless fears—of poverty, of greater incapacity, of being a burden to others.

(4) In quite a number of cases elderly people are unaware of some of the sources of financial and other help available to them.

(5) There are also many problems of physical health, *e.g.*, the old man who demonstrates his "youthfulness" by running for buses at risk of coronary thrombosis, the elderly woman who needlessly treats herself as a semi-invalid because she is "nearly 70," the heavy manual worker who, after retirement, eats as much as in his days of strenuous toil and thereby increases his liability to various diseases, the elderly woman to whom cooking has become a weariness and who subsists mainly on tea and bread until (through lowered resistance) infection supervenes, and the old man who becomes housebound through remediable foot defects (such as ingrowing toe nails).

(B) Existing Sources of Help.

(1) The Corporation's health visitors are equipped to advise elderly citizens on the various problems listed above. Since the Ministry of Health, in discussing the rôle of the health visitor in the care of the elderly, has seen fit to summarise an article by the Principal Health Visitor Tutor of Aberdeen, I probably cannot do better than to repeat that summary: the health visitor's work with the elderly includes—

- (a) work concerned with the preparation for ageing (*e.g.*, advice on leisure interests in preparation for retirement);
- (b) maintenance of health in those who have already crossed the threshold of age (*e.g.*, alleviation of loneliness and fears, advice on diet and exercise, &c.);
- (c) co-ordination of the services available (*e.g.*, seeing that the old person applies for any necessary allowances, persuading him to enter a home if desirable, calling in the home help service if needed); and
- (d) social research (*i.e.*, accumulation of information on which future policy of Health Departments and Welfare Departments can be based).

It may be mentioned that the development of domiciliary services in Aberdeen (especially health visiting and chiropody) has already resulted in a considerable reduction of the estimate of hostel places needed: in other words, the policy of trying to maintain the health of elderly citizens is benefiting the community's purse as well as increasing the happiness of old people.

(2) Other services are available at need—home helps, chiropody, district nursing service, the mobile meals service, and, for those incapable of maintaining a completely independent existence, residential homes. Old people's clubs also perform a very useful function, and the rôle of the kindly neighbour must never be forgotten.

(C) Gaps in the Help Provided.

A sitter-in service (mentioned earlier) would be beneficial, as would geriatric clinics for routine health overhauls (on the lines of those provided for children at child welfare clinics and school medical examinations).

However, apart from a lack of houses suitable for elderly persons, it can be claimed that the services for old people in Aberdeen are at least as good as those in any other town in Britain. (In substantiation of this claim, I would mention (a) that I was invited to address an international geriatric conference, held in London, about services for the elderly at home, and (b) that the B.B.C. has selected Aberdeen for inclusion in radio and television programmes about the well-being of the elderly.)

IX. PROBLEM FAMILIES.

It should be noted that the term does not mean families with a problem (*e.g.*, long-term illness or prolonged unemployment); it means the hard core of undesirable families whose cleanliness, morality, social conduct, and ways of life are habitually below the normal for the community—feckless, improvident, dirty families, constantly needing help from all agencies concerned but resistant to reclamation.

The records of the Health and Welfare Department show 251 families in this category (but, for purposes of supervision and follow-up, the term “problem family” has been widened to include a number of borderline families, so that it would probably be fairer to say that Aberdeen has about 150 problem families and about another 100 families on the borderline).

(A) Problems Liable to Arise.

(1) Effects of squalid, smelly houses, unplanned meals, irregular sleep, uncleanness and so forth on children—*e.g.*, high child morbidity, malnutrition, poor school attendance, educational retardation, delinquency, &c.

(2) Similar effects after childhood—*e.g.*, anti-social behaviour, petty crime, illegitimacy, prostitution.

(3) Effects on neighbours.

(4) Problems of eviction for non-payment of rent, &c.

(5) Problems of destruction of property.

While these problems have to be tackled individually (*e.g.*, by work of school attendance officers, police, probation officers, &c.), it is probably more useful to consider these sub-standard families as a whole under three heads—causes, treatment, and prevention.

(a) Causes.

1. Mental deficiency, especially of the mother. She, rather than the father, sets the tone of the house. Broadly, one-third of problem parents are mentally defective and a good many others are borderline.
2. Prolonged poverty (*e.g.*, prolonged unemployment) causing gradual disheartenment and falling standards. Poverty in the early years of married life is probably particularly important, when the mother has the additional strain of rearing babies.

3. Bad housing—to some extent an aggravating factor rather than a cause, but in any slum the housewife lacks the space and the tools for efficiency.
4. Families too large and unspaced—hence less food and less clothing available per head, and mother attending to latest baby lacks time for several toddlers.
5. Poor health and untreated illness (*e.g.*, chronic anæmia)—partly a cause and partly an effect.
6. Marital disharmony—perhaps more an effect than a cause.
7. Drunkenness—a factor of decreasing importance and more an effect than a cause.

In most cases a combination of several causes is present, but, broadly, mental inadequacy is the main cause in one third, poverty and bad housing are the main causes in another third, while a mass of factors operate in the remaining third.

(b) *Need for Prevention and Treatment.*

It is sometimes argued that we should not spend too much on these people as they are “the dregs of humanity” and often incapable of reclamation: but it is impossible to raise the general level of the community if, in about every 120 families, there is one that is filthy, verminous, sub-standard, and spreading disease. Also prevention or early treatment is essential to save the community the high cost of later services—police, warders, &c.

Moreover, only by improving the conditions of these families can we hope to prevent the children from becoming the problem parents of the next generation.

A circular issued by the Secretary of State for Scotland on 1st December, 1954 (and a parallel circular issued by the Minister of Health in England and Wales) stressed the need for local health authorities to expand their preventive services *as a matter of over-all economy to public funds*. Measures mentioned in the circular included—the use of social workers or specialist health visitors for intensive work with problem families; more visiting by district health visitors, with increase of health visiting staff where required; adequate exchange of information between all health workers; and home helps to work with the mothers.

(c) *Treatment.*

Careful assessment of the individual family is essential, followed by division into categories—

1. If family is mentally defective and socially ineducable, little can be done except stringent supervision and removal of children to care of Children's Department. Unfortunately, these intractable families are the very ones that tend to breed prolifically, *e.g.*, one couple producing 12 mentally defective children each maintained in an institution at

£250 per annum, will cost the community £3,000 a year, or a total of £150,000 if the defectives have an average life of 50 years. (Hence the importance of prevention, as discussed later.)

2. If they are socially educable and capable of responding to help, the aims must be material help (equipment, clothing, food, improvement of conditions), encouragement, and teaching—in that order. Advice about house management, budgeting, and cooking must follow (not precede) material help. It is important to appreciate that a problem family (with limited intelligence and weak personality) is of all families the least fitted to cope with additional handicaps: therefore, if such a family is regarded as capable of reclamation, it should be given good housing conditions. To re-house a problem family in slightly better but still sub-standard conditions is undesirable unless the family has been classified as beyond hope.

Family Service Units and Special Hostels for Neglectful Mothers would be of considerable value.

(d) *Prevention.*

Some hopeful measures include—

1. *Health education* of children, adolescents, expectant mothers, nursing mothers, &c. Education in homecraft and house management is important. The rôle of the health visitor is basic, but much could also be done with senior children in schools.
2. *Improvement of social conditions.* The better the conditions, the fewer borderline families will descend into the problem group.
3. *Removal of sources of strain*, since an additional strain imposed on a family with low income, bad housing, and limited capacity may precipitate that family into the problem group. As an example, the admission of a young child to a day nursery may relieve a "borderline" mother of some strain.
4. *Family planning.* Proper spacing of families before the mother becomes exhausted by a series of pregnancies and before the older toddlers become neglected through inattention.
5. *Measures to reduce illegitimacy* (since many problem families are largely illegitimates)—*e.g.*, by guiding parents to avoid excess strictness with children, by provision of facilities for healthy recreation, by sex instruction in schools as part of a course in elementary physiology, and by adequate ante-natal and post-natal care of the unmarried mother and her resettlement in normal life.

(B) Sources of Help Available.

(a) For Prevention.

Health visitors in the home and mothercraft teachers in schools try to supply the necessary education, and the Corporation has recently approved of the setting up of a Health Guidance Section in the Health and Welfare Department. Nurseries are available to reduce strain, as are home helps. A family planning clinic is available. Increasingly parents are being advised about the requirements of children. The unmarried mother is the subject of considerable attention.

(b) For Treatment.

The health visitor, the sanitary inspector, the school attendance officer, the children's visitor, the R.S.P.C.C. inspector, the probation officer, and officers of the N.A.B. are all concerned. Their work is to some extent co-ordinated by a Committee which meets, under the chairmanship of the M.O.H., as required.

(C) Gaps in the Help Provided.

(1) Shortage of housing accommodation.

(2) Staff shortages, especially of health visitors.

(3) A Family Service Unit would be useful.

(4) A hostel for neglectful mothers would be useful, but discussions have led to the belief that Aberdeen is not quite large enough to maintain such a hostel.

(5) Measures for the cure of confirmed methylated spirit drinkers (of whom there are about a dozen in the City) would be useful: informal discussions are at present being held with the procurator-fiscal, the Secretary of the Association of Social Service, and other interested parties.

(6) Perhaps the Health and Welfare Department should have, in addition to health visitors, a small number of male visitors. At present it has only one. (Without wishing to tread on the toes of the Education Committee, I would offer for consideration the suggestion that, at a suitable time, the School Welfare—*i.e.*, Attendance—Officers might be placed under the ægis of the School Health Section of the Health and Welfare Department and that, thereafter, the health visitors might undertake all school attendance duties in respect of younger children—whose homes they are usually already visiting—while the male officers might devote the time thus saved to more intensive work with older boys, especially those from problem and borderline families.)

FOOT-NOTE: A WORD ON THE WELFARE DEPARTMENT.

This report will be regarded as a report by the Medical Officer of Health, and it frequently mentions medical officers and health visitors. Because of the "medical" slant of these terms it may be thought that the report deals with "health" problems rather than with "social" problems (though the two are really inseparable). To

obviate any such misconception I should like to end this regrettably lengthy report with a few words about the Welfare Department.

Until 1948 the Corporation had an active Welfare Department under the control of a Director of Welfare. Had the department remained independent it would subsequently have expanded greatly, *e.g.*, because of the development of services for elderly persons and the physically handicapped.

In 1948 the Corporation amalgamated its Health Department and its Welfare Department (and, incidentally, the Committee on Economies in the National Health Service has this year strongly recommended that local authorities which have not yet done so should amalgamate these departments). But amalgamation does not mean the extinction of the smaller component. There is still a Welfare Department (with an annual gross budget of about £80,000) although it exists as a part of a larger department; there are still welfare visitors, although in the interests of efficiency and economy most visiting in connection with both social welfare and health matters is entrusted to a trained social worker with a nursing background, the Health Visitor; there is still a Director of Welfare (who has to sign himself as such on various documents) although he is generally referred to as the Medical Officer of Health.

In most of this report I have written less as a health officer than as Director of Welfare.

3.—VITAL STATISTICS OF 1956.

Some of the main features of the year are—

- (1) The live-birth rate is the highest recorded since 1949.
- (2) The illegitimate-birth rate is a shade lower than in 1955 but higher than in 1954.
- (3) The still-birth rate is higher than it has been for some years, although it remains lower than the rate for Scotland and lower than for any other Scottish city.
- (4) The infant-mortality rate, although higher than in various Scandinavian cities and some English cities, is lower than in other Scottish cities and Scotland as a whole; the rate is, however, a shade higher than the 1955 low record.
- (5) The neonatal-mortality rate, while higher than in 1955, is still lower than in any other Scottish city.
- (6) For the second year in succession there was only one maternal death.
- (7) The average age at death is lower than in 1955 and 1954.
- (8) The proportion of deaths in persons under the age of 45 years has been falling for some years, and the low record of 9 per cent. for 1954 has been maintained.
- (9) The proportion of deaths in persons aged 75 years and over has been rising steadily for some years, and a new high level of 40 per cent. was reached in 1956.
- (10) The "health indicator" suggested by the World Health Organisation gives 1955 as the healthiest year in Aberdeen's history and 1956 as the second healthiest year.
- (11) Any one regression from last year, *e.g.*, in infant-death rate, in still-birth rate, in the "health indicator," or in average age at death, is small and might well be due to chance; but, taken together, these slight regressions suggest a deterioration in the health of the community—as was forecast in the 1955 Report owing to the shortage of professional staff and particularly of health visitors.

The table on page 28 gives the numbers of births, still births, and infant deaths over a series of years.

LIVE BIRTHS.

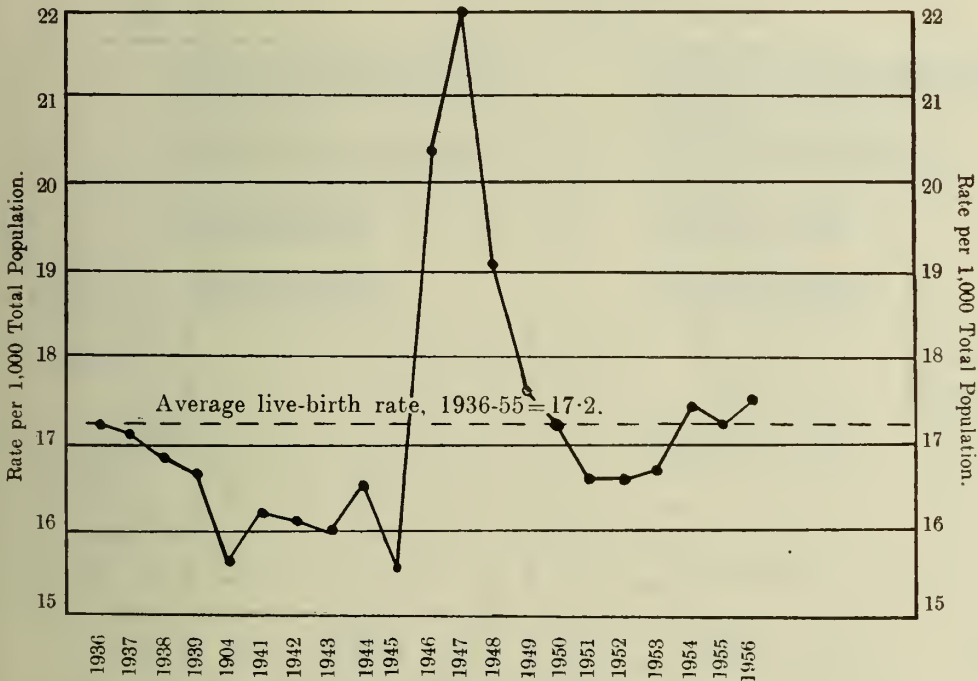
The total number of live births in the City during 1956, corrected for "transfers," was 3,271, of whom 3,099 were legitimate and 172 illegitimate. The live birth-rate was 17·5 per 1,000 of population, a slightly higher figure than in most recent years.

The following table shows the rates for Aberdeen and Scotland over a period of ten years. The trend in Aberdeen is very similar to that in the country as a whole:—

Year.	Live Birth Rate per 1,000 Population.		
	Aberdeen.	Scotland.	
1956	17·5	...	18·5
1955	17·2	...	18·0
1954	17·4	...	18·0
1953	16·6	...	17·8
1952	16·5	...	17·7
1951	16·5	...	17·7
1950	17·2	...	17·9
1949	17·5	...	18·5
1948	19·1	...	19·4
1947	22·0	...	22·0

In 1956 the birth-rates in the other principal cities were:—Glasgow, 20·2; Edinburgh, 16·0; and Dundee, 19·2.

ABERDEEN.—LIVE-BIRTH RATE-- 1936-1956.



The natural increase for the year (*i.e.*, the excess of births over deaths) was 1,116, as compared with 1,069 in 1955, 1,172 in 1954, 986 in 1953, and 877 in 1952.

BIRTHS, STILL-BIRTHS, INFANT MORTALITY. YEARS 1946-1956.

YEAR.	No. of Live Births.	Live Births per 1,000 of Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 4 Weeks.	Neo-natal Deaths per cent. of Total Infant Deaths.	Rates.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births.											
									Total under one Year.	(Neo-natal Rate) Under 4 Weeks.	4 Weeks and under Six Months.	Six Months and under One Year.	Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhea and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasis.	Immaturity.	Accidents.	Other causes.		
1956 .	3271	17.5	5.3	71	21	73	45	62	22.3	13.8	6.1	2.4	0	0	5	1	3	1.5	2.8	5	2	2	3	2
1955 .	3204	17.2	5.4	40	12	66	36	55	20.6	11.2	5.3	4.1	0	1	4	0	3	0.3	3.4	4	2	2	3	3
1954 .	3228	17.4	4.3	64	19	70	50	71	21.7	15.5	4.3	1.9	0	0	5	0	3	1	7	2	2	0.3	4	4
1953 .	3077	16.6	4.5	62	20	84	57	69	27	19	6	2	0	0	6	0.3	4	2	8	3	3	1	3	3
1952 .	3025	16.5	5.7	57	18	90	54	60	30	18	8	4	0	0	6	0	5	1	8	2	2	1	7	7
1951 .	3028	16.5	5.4	66	21	82	55	67	27	18	6	3	0	1	6	0.3	4	2	5	6	2	2	1	1
1950 .	3226	17.2	5.3	74	22	92	54	54	29	17	10	2	0	0.3	6	0.3	5	2	4	5	2	2	5	5
1949 .	3306	17.5	5.7	63	19	100	54	54	30	16	12	2	0.3	1	7	3	5	1	5	4	1	3	3	3
1948 .	3598.	19.1	5.9	98	27	121	72	60	34	20	10	4	0	1	5	5	4	4	5	6	2	2	2	2
1947 .	4124	22.0	5.9	107	25	263	108	41	64	26	28	10	0.2	2	13	22	4	2	8	5	2	2	6	6
1946 .	3762	20.4	7.0	115	30	158	92	58	42	24	16	2	0.5	0.3	6	9	5	3	7	7	1	3	3	3

*Including under 4 Weeks.

Sex-ratio of births.—Of the total 3,271 live births, 1,717 were males and 1,554 were females, giving a ratio of 1·10 (*i.e.*, 110 males per 100 females). The sex-ratio in Aberdeen has been consistently high in recent years; it was 1·05 in 1955, 1·10 in 1954, 1·07 in 1953, 1·09 in 1952, and 1·11 in 1951.

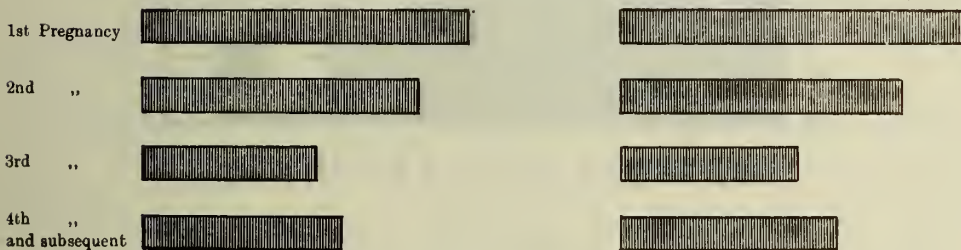
Analysis of Births.

LEGITIMATE LIVE BIRTHS.

(N.B.—Figures here refer to women living in Aberdeen and confined in Aberdeen, and therefore differ slightly from the totals given elsewhere in this Report.)

	1955.	1956.
First Pregnancy	1,042	1,074
Second Pregnancy	865	882
Third Pregnancy	557	559
Fourth and subsequent Pregnancy	617	637
	<u>3,081</u>	<u>3,152</u>

LEGITIMATE LIVE BIRTHS.



LEGITIMATE:—LIVE BIRTHS, STILL BIRTHS, AND INFANT DEATHS—AGE OF MOTHER.

AGE OF MOTHER	Live Births		Still Births		Neonatal Deaths		Other Infant Deaths	
	1955	1956	1955	1956	1955	1956	1955	1956
Under 20 years	142	179	2	3	2	3	2	2
20—24 „	1,017	1,020	12	23	9	11	13	9
25—29 „	1,000	1,023	10	18	10	16	4	9
30—34 „	628	574	10	18	7	7	6	2
35—39 „	226	309	4	5	4	3	2	1
40+ „	68	56	2	3	1	—	1	—
	<u>3,081</u>	<u>3,152</u>	<u>40</u>	<u>70</u>	<u>33</u>	<u>40</u>	<u>28</u>	<u>23</u>

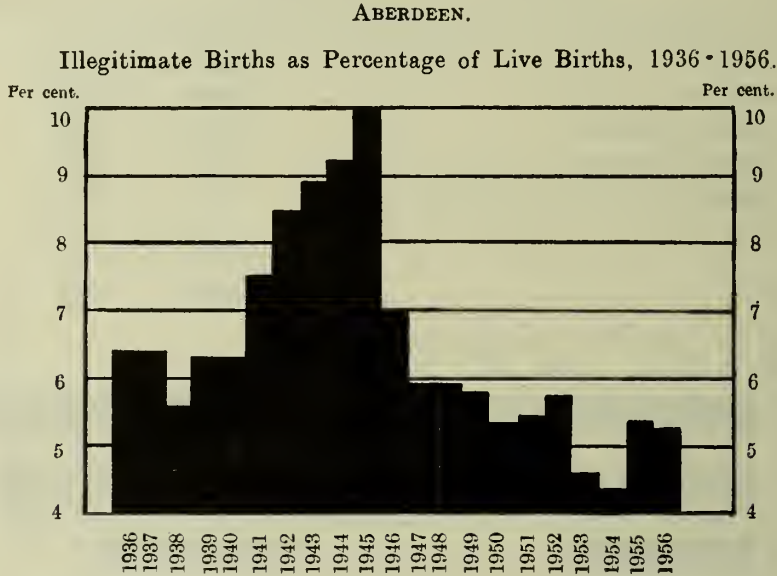
ILLEGITIMATE LIVE BIRTHS.

In 1956 there were 172 illegitimate live births, representing a rate of 5·3 per cent. of the total live births. For Scotland, the rate was 4·3 per cent.

For many years illegitimacy has been a very grave social problem in Aberdeen, and the illegitimate-birth rate has been high. The rate for 1956 is the third lowest in the history of the City.

Some possible explanations of the high illegitimacy rate in Aberdeen were suggested in the Report for 1955.

The diagram indicates how the illegitimate-birth rate has changed over the years.



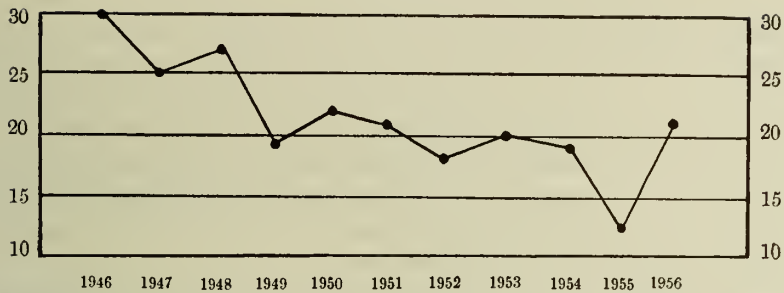
STILL BIRTHS.

There were 71 still births in 1956, giving a rate of 21 per thousand total births, as compared with rates of 12 in 1955 and 19 in 1954.

As was mentioned in the report for 1955, the phenomenally low still-birth rate for that year was regarded as being in some part due to chance. Nevertheless, it is disappointing to find that the still-birth rate for 1956 is higher than it has been for some years. The following Table, however, shows that the still-birth rates of Aberdeen continue to compare favourably with those of other cities, and the graph shows the changes in the rate in Aberdeen over the last eleven years.

		Still-birth Rate per 1,000 Total Births.					
		1956.	1955.	1954.	1953.	1952.	1951.
All Scotland	. . .	24	25	25	25	26	27
Glasgow	. . .	26	27	29	27	27	28
Edinburgh	. . .	23	24	21	22	27	27
Dundee	. . .	23	24	28	25	24	25
Aberdeen	. . .	21	12	19	20	18	21

ABERDEEN.—STILL-BIRTH RATE—1946-1956.



Analysis of Still Births.—Detailed information is available for all the still births, and from this it was ascertained that 21 (or 30 per cent.) were primipara pregnancies, 17 (or 24 per cent.) were second pregnancies, 13 (or 18 per cent.) were third pregnancies, and the remaining 20 (or 28 per cent.) were subsequent pregnancies. The following summary shows the ages of the mothers:—

	TOTAL	AGE OF MOTHER					
		Under 20 years	20-24	25-29	30-34	35-39	40 +
1st Pregnancy	21	2	13	2	3	—	1
2nd Pregnancy	17	1	8	5	2	1	—
3rd Pregnancy	13	—	3	6	4	—	—
Subsequent Pregnancies	20	—	—	5	9	4	2
TOTAL ...	71	3	24	18	18	5	3

The causes of the still births were as follows:—

Chronic disease in mother—

Hypertension	2
Anæmia	1
	— 3

Diseases and conditions of pregnancy and childbirth—

Antepartum hæmorrhage	14
Toxæmia of pregnancy	6
	— 20
Trauma	2
Trauma—Cord conditions	4
Placental infarct	1
	— 7
Congenital malformation of foetus	12

Diseases of foetus and ill-defined causes—

Rhesus factor	5
Prematurity—Cause unknown	12
Full term—Cause unknown	12
	— 29

INFANT DEATHS.

It is interesting to note the figures for the last four years.—In 1953, there were 84 deaths of babies under the age of one year, giving a rate of 27 per thousand live births, and no lower rate had ever been recorded in Aberdeen. In 1954, there were 70 baby deaths, giving an infant-mortality rate of 22 per thousand live births. In 1955, there were 66 baby deaths, giving an infant-mortality rate of 21, and in 1956 there were 73, giving a mortality rate of 22. A glance at the table on page 36 will reveal that, as recently as nine years ago (1947), the number of baby deaths was 263 and the infant-mortality rate was 64, while thirty years ago the infant-mortality rate fell below 100 for the first time.

No great significance is to be attached to the rise in the infant-death rate in 1956 by a single point. While the slight rise might be associated with the severe shortage of health visitors in the latter part of 1955 and most of 1956, it might equally be a matter of chance. What is more important is that, after falling steadily from 1952 to 1954, the infant-death rate is now tending to remain stationary. In this connection, it should be remembered that, although the rate appears very low when compared with that of Scotland as a whole, it still compares unfavourably with some English cities and even more unfavourably with the rates obtaining in such countries as Sweden and New Zealand. In considering the Aberdeen infant-mortality rate, however, two environmental points must be kept in mind—

- (1) As indicated in the section on background data, Aberdeen and Glasgow have a higher proportion of persons in the lowest social class than have other cities or Scotland as a whole, and Aberdeen has a larger proportion in the two lowest social classes than has Glasgow.
- (2) As indicated in the paragraph on housing, Aberdeen—despite its vigorous housing programme—compares unfavourably with other cities.

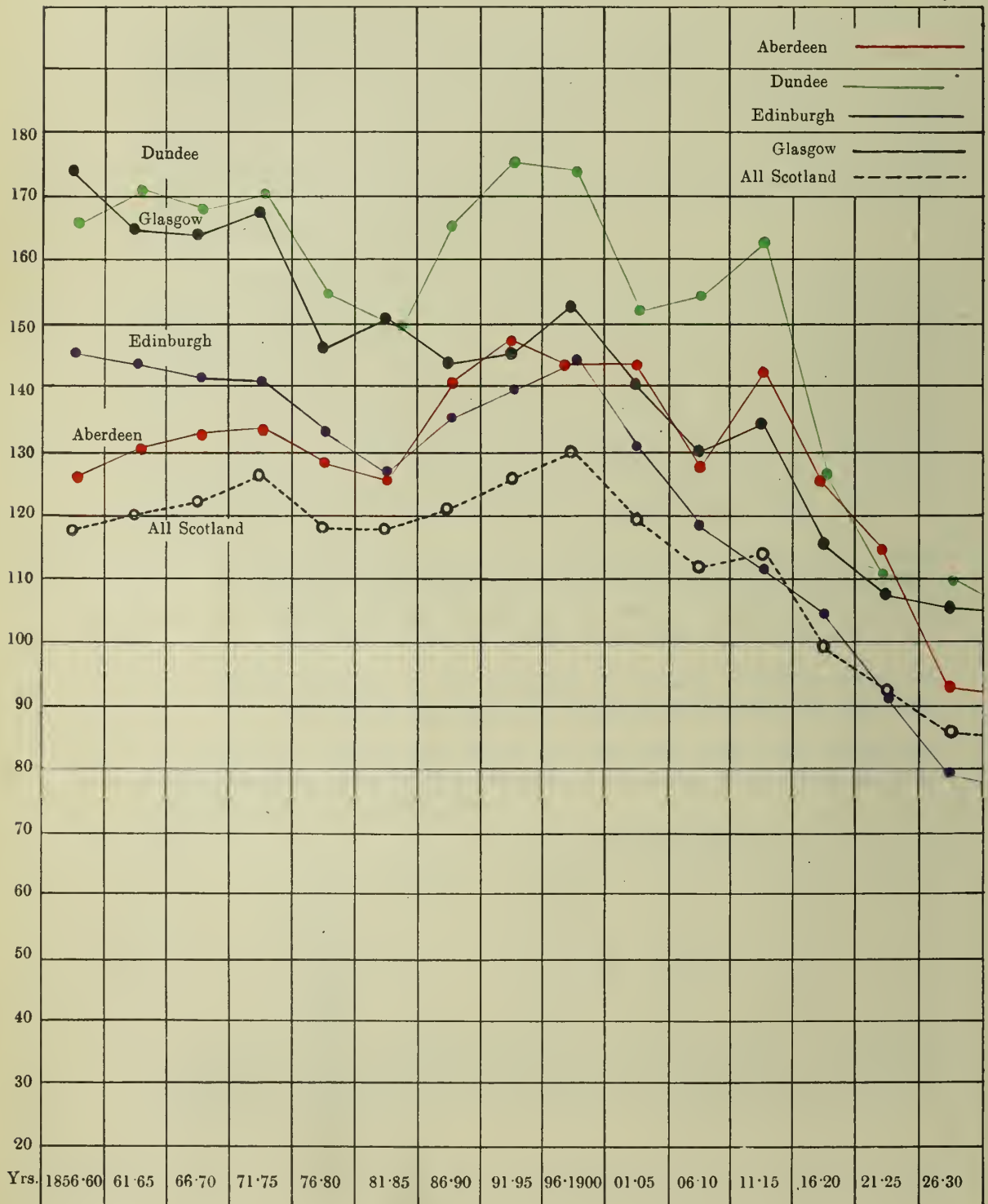
Comparison with National Figures and with other Cities.—The average rates for England and Wales and for Scotland, as well as for the four principal cities, are given below for the last five years—

	Infant Death Rates.				
	1956.	1955.	1954.	1953.	1952.
England and Wales .	24	25	26	27	28
Scotland . . .	29	30	31	31	35
Glasgow . . .	34	36	35	36	41
Edinburgh . . .	24	25	25	24	29
Dundee . . .	31	36	33	32	31
Aberdeen . . .	22	21	22	27	30

The accompanying coloured chart shows the infant mortality rate in Scottish cities and in Scotland as a whole since 1856, and a table (inserted after the subsection on mortality in pre-school children) shows the actual number of deaths in Aberdeen in various years.

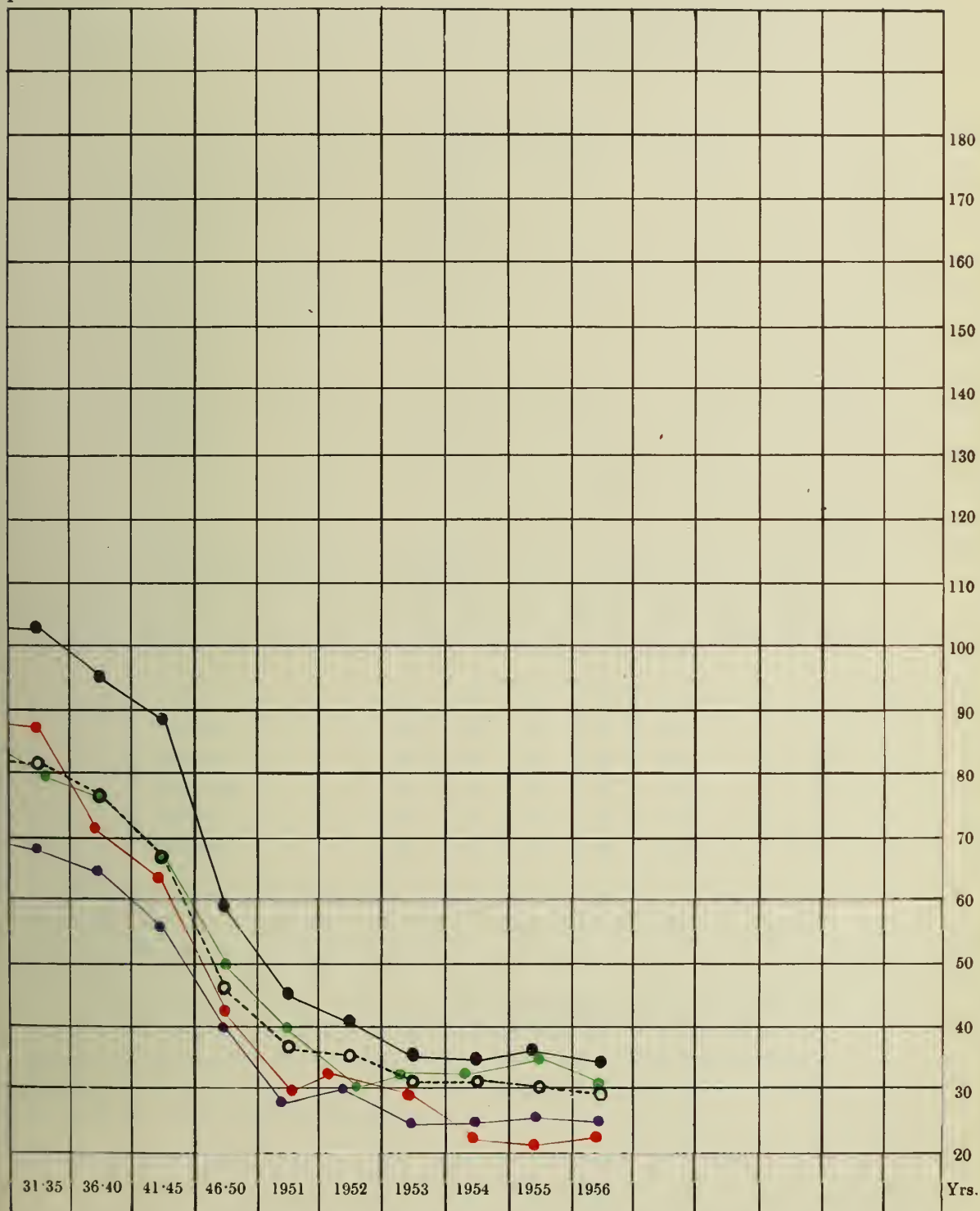
INFANT MORTALITY RATE— 1856-1956.—

Deaths under 1 year



—QUINQUENNIAL AVERAGES, 1856-1950.

per 1,000 Births.





Causes of Infant Deaths.—Table I, at the end of this section of the Report, gives details of the causes of death and the age at which each child died. An analysis of the infant deaths that have occurred during the last five years reveals that the death rates from various causes were as follows:

	Infant Death Rates per 1,000 Live Births.				
	1956.	1955.	1954.	1953.	1952.
Congenital malformations	3	3	3	4	5
Atelectasis	2.8	3.4	7	8	8
Birth injuries	1.5	0.3	1	2	1.3
Diarrhoea and enteritis	1	0	0	0.3	0
Pneumonia and bronchitis	5	4	5	6	6
Common infections	0	1	0	0	0
Tuberculosis	0	0	0	0	0
Asphyxia and other accidents	2	2	0.3	1	1
Immaturity	5	4	2	3	2.3
Other causes	2	3	4	3	6
	—	—	—	—	—
Total	22	21	22	27	30
	==	==	==	==	==

Neo-Natal Deaths.—In 1956, the number of deaths of infants under the age of four weeks was 45, as compared with 36 in 1955, 50 in 1954, and 57 in 1953. The neo-natal death-rate was 14 per thousand live births. The neo-natal death-rates for Scotland and for the four principal cities in 1952-1956 are as follows:—

	Neo-natal Death Rates.				
	1956.	1955.	1954.	1953.	1952.
Scotland	19	20	21	19	22
Glasgow	21	23	21	22	24
Edinburgh	18	18	19	16	17
Dundee	21	21	23	20	20
Aberdeen	14	11	15	19	18

Post-Natal Deaths.—In 1956, there were 28 deaths of infants aged 4 weeks to 12 months as compared with 30 in 1955. For further analysis, reference may be made to Table I at the end of this chapter.

Deaths under the age of one week.—Although the conventional division of infant deaths is into neonatal (under one month) and post-neonatal, it is also useful to separate out the deaths occurring before the age of one year. From the following diagram, it will be seen that, in three of the last four years, more babies died in the first week than in the remaining fifty-one weeks.

When it is recalled that still births are nearly as numerous as infant deaths, it becomes clear that approximately three-quarters of the total loss of baby lives must be related to prenatal and intranatal factors. Therefore, to reduce that loss, we must think not in terms of additional services for mother and child but rather in terms of services for the prospective mother and unborn child, *e.g.*, the provision of more or better advice to expectant mothers by health visitors in the privacy of the home, the provision of health talks for prospective parents (on the lines of these started at the end of 1956), and measures to induce an even higher proportion of expectant mothers to attend clinics for obstetrical care by doctors and midwives and for medico-social advice and health teaching by doctors and health visitors.

Aberdeen is in a favourable situation in that—

- (1) The overwhelming majority of expectant mothers attend the ante-natal clinics;
- (2) Standards of ante-natal care—both as provided by doctors, health visitors, and midwives at the clinics and as provided by health visitors and midwives in the home—are very high;
- (3) Standards of obstetrical care are also very high;
- (4) In the ante-natal services there is complete co-operation between the clinicians of the Regional Hospital Board and the public health doctors and public health nurses of the local health authority; and
- (5) Courses of health talks for expectant mothers have now been organised.

Nevertheless, every effort should be made to convert a favourable situation into an even more favourable one.

MORTALITY IN PRE-SCHOOL PERIOD (1-5 years).

During 1956, 9 children, aged 1-5 years, died. Comparative figures are—

	Number of deaths in			
	1956.	1955.	1954.	1953.
1 - 2 years	4	4	2	8
2 - 3 years	—	1	3	4
3 - 4 years	2	6	2	4
4 - 5 years	3	2	1	3
	—	—	—	—
	9	13	8	19
	==	==	==	==

Of the 9 deaths in 1956, 4 were due to accidents (3 on roadway, 1 in home), 1 to congenital malformations, 2 to respiratory diseases, and 2 to miscellaneous causes. There has now been only one death from home accidents in three consecutive years.

160

140

120

100

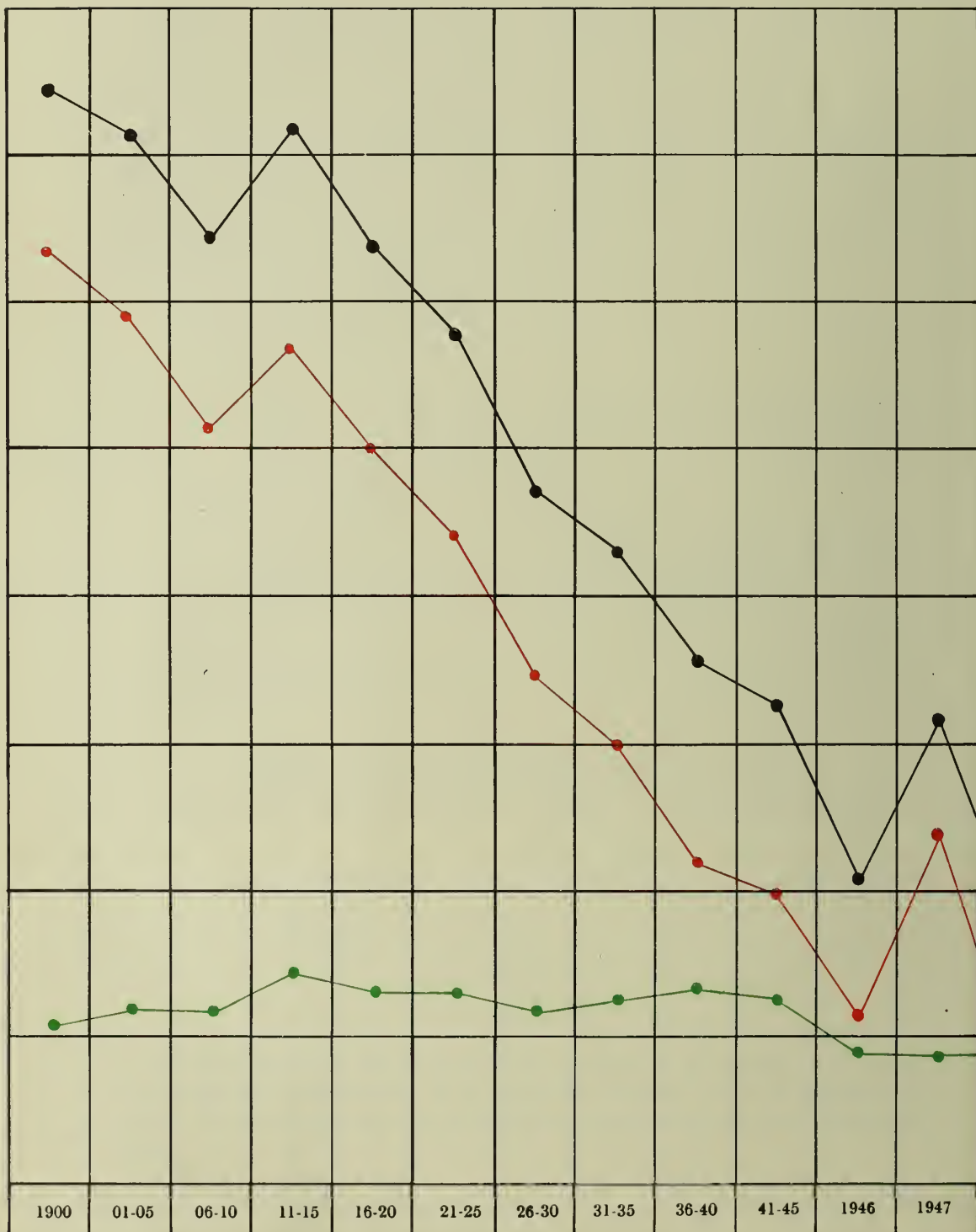
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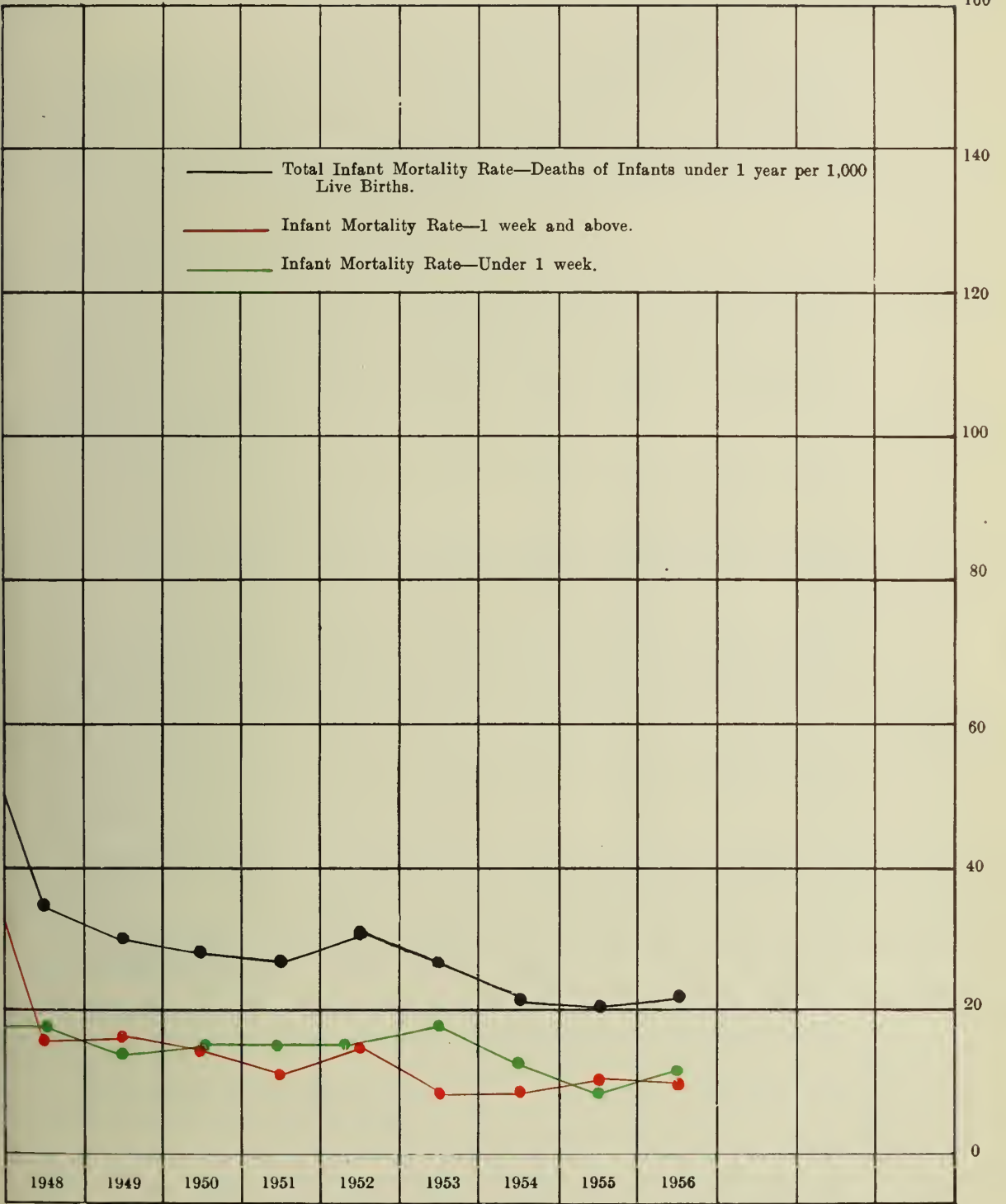
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INFANT MORTALITY—1900-1956.



DECLINE IN INFANT AND PRE-SCHOOL DEATHS.

In 1904 (when deaths were first allocated by the Registrar-General to the place in which the deceased had lived, instead of simply the place where they died), 733 infants under one year and 367 children aged 1-5 years died in Aberdeen, a total of exactly 1,100 young deaths. In 1956, there were 73 deaths of infants under 1 year and 9 of children aged 1-5 years, a total of 82.

Some of the main factors in the decline were given in last year's Report but may be repeated here—

(1) The gradual development of the disease-preventing and health-promoting services of the Health Department (re-named, since 1948, the Health and Welfare Department). In this connection, it is worthwhile to note that, in the burghs of Scotland at two different periods investigated, a highly significant correlation has been found to exist between the infant death rate and the degree of inadequacy of health visitor staffing.

(2) Increase of health education (which is, perhaps, the most important facet of the work of a Health Department).

(3) The eradication of various infectious diseases by specific immunisation, contact tracing, isolation of patients, sanitary and hygienic measures, &c.

(4) Improvements in the standard of living and, in particular, better nutrition. This factor may be taken as including both the changes in living standards consequent on increases in the earnings of the lowest paid sections of the community and the changes produced by advice to housewives on wise spending of the money available.

(5) Better housing. We perhaps tend to be so aware of the problem of overcrowding and unsatisfactory housing to-day that we are in danger of forgetting how infinitely worse were circumstances in the past.

(6) Better ante-natal and obstetrical care. This factor may be taken as including both the clinical and the preventive and medico-social aspects.

(7) Development of medical knowledge and provision of better treatment facilities for sick children.

(8) Establishment of the family planning clinic, spread of knowledge of contraceptive techniques, and social recognition of the desirability of the spaced family.

(9) Measures for the reduction of illegitimacy, and measures for the better care of the unmarried mother and her child.

The following table gives the infant death-rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.
1905 .	138	678	233	911	1931 .	90	292	69	361
1906 .	127	599	273	872	1932 .	93	296	98	394
1907 .	125	561	256	817	1933 .	79	238	94	332
1908 .	129	577	260	837	1934 .	77	235	80	315
1909 .	149	671	277	948	1935 .	91	286	118	404
1910 .	111	478	167	645	1936 .	70	214	77	291
1911 .	139	563	285	848	1937 .	72	219	62	281
1912 .	127	530	232	762	1938 .	71	215	78	293
1913 .	152	591	400	991	1939 .	59	177	38	215
1914 .	121	487	259	746	1940 .	86	241	70	311
1915 .	173	654	405	1,059	1941 .	77	224	39	263
1916 .	112	398	182	580	1942 .	67	194	39	233
1917 .	139	399	270	669	1943 .	68	195	34	229
1918 .	143	390	267	657	1944 .	57	169	36	205
1919 .	118	399	159	558	1945 .	54	152	34	186
1920 .	121	591	144	735	1946 .	42	158	25	183
1921 .	108	460	80	540	1947 .	64	263	19	282
1922 .	133	527	284	811	1948 .	34	121	14	135
1923 .	104	391	156	547	1949 .	30	100	23	123
1924 .	122	421	207	628	1950 .	29	92	19	111
1925 .	109	368	143	511	1951 .	27	82	16	98
1926 .	96	328	105	433	1952 .	30	90	13	103
1927 .	105	334	101	435	1953 .	27	84	19	103
1928 .	94	313	142	455	1954 .	22	70	8	78
1929 .	95	297	113	410	1955 .	21	66	13	79
1930 .	80	265	85	350	1956 .	22	73	9	82

The gross numbers are, of course, a poorer guide than the rates; in a year in which the birth-rate was high (*e.g.*, 1955 or the four consecutive years 1946-1949) the number of baby deaths would—other things being equal—normally be larger than in a year in which the birth rate was low (*e.g.*, 1951 or 1952). Even the rates are, of course, subject to slight variation from statistical chance; for instance, it would be unreasonable to argue that the health and health services of the City were worse in 1937 (when the infant death rate was 72) than in the previous year (when it was 70); but the general trend is clear enough.

MORTALITY IN SCHOOL PERIOD.

In 1956 there were 11 deaths of children of school age (as compared with 13 in 1955). The causes were as follows:—drowning accidents, 4; accidents on roadway, 3; malignant neoplasms, 2; and miscellaneous causes, 2.

MARRIAGES.

During 1956, there were 1,965 marriages within the City. This is equivalent to a rate of 10·5 per thousand of the population. The rates in previous years were—1955, 10·6; 1954, 10·2; 1953, 10·4; 1952, 10·5; 1951, 10·0; 1950, 9·9; and 1949, 9·7.

MATERNAL MORTALITY.

In Aberdeen, during 1956, there was 1 death from causes related to pregnancy and childbirth. In 1955 there was also 1 death, in 1954 there were 2, and in 1953 there were 7 deaths, including 2 in which the death was ascribed to puerperal sepsis. When deaths are down to small numbers, it is probably wiser to study the average figures for a series of years, as in the last line of the table below, which gives a comparison between Aberdeen and all Scotland in recent years:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1956	0.51	0.3	0.15	0.0	0.36	0.3
1955	0.45	0.3	0.12	0.0	0.33	0.3
1954	0.7	0.6	0.16	0.0	0.58	0.6
1953	0.9	2.2	0.2	0.6	0.7	1.6
1952	1.0	0.6	0.2	0.0	0.8	0.6
Average 1952-1956	0.7	0.8	0.16	0.1	0.56	0.7

DEATHS.

The total number of deaths, the death rate per 1,000 of population, and the average age at death for each of the years 1950-1956 are given in the following table:—

Year.	Number.	Rate per 1,000 of Population.	Average age at Death.
1956	2,155	11.6	65.9
1955	2,135	11.5	66.7
1954	2,056	11.1	66.3
1953	2,091	11.3	65.1
1952	2,148	11.7	64.6
1951	2,181	11.9	65.7
1950	2,266	12.1	64.9

For all Scotland, the death rate was 12.0 in 1956, 12.0 in 1955, 12.0 in 1954, 11.5 in 1953, and 12.0 in 1952.

AGE AT DEATH.

The average age at death of all persons dying during 1956 was 65.9 years, as compared with 66.7 in 1955, 66.3 in 1954, 65.1 in 1953, and 64.6 in 1952. (1954 was the first year in which the average age at death reached 66.) It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32.9 years, and that, as recently as twelve years ago (1944), it was 58.4 years.

Of the 2,155 deaths, 188 (or 9 per cent.) were in persons below the age of 45 years. In 1955 the figure was 190 (or 9 per cent.); in 1954, 193 (or 9 per cent.); in 1953, 233 (or 11 per cent.); and in 1952, 267 (or 12 per cent.). An analysis of these 188 young deaths by cause is as follows:—

Malformations and diseases of early infancy	48
Violence	32
Malignant neoplasms	33
Disease of the circulatory system	18
Pneumonia and bronchitis	16
Diseases of nervous system	9
Diseases of digestive system	8
Tuberculosis	7
Diseases of genito-urinary system	5
Infectious and parasitic diseases: malaria	1
Puerperium	1
Miscellaneous	10

The gradual reduction in the number of deaths from infections and violence in this age-group is particularly noteworthy. It is, however, well worth while to look carefully at this list of deaths in the first 45 years in order to ask the question—in respect of the main causes, are we as yet doing all that we can to prevent them?

538 (or 25 per cent.) of all deaths occurred in the age-period 45-64 years, so that a total of 726 fatalities (or 34 per cent.) occurred before the age of 65 years. 566 deaths (or 26 per cent.) occurred in the age-period 65-74 years, and 863 (or 40 per cent.) occurred at ages of 75 and over. The percentages of all deaths occurring at ages of 75 and over were—40 in 1956, 39 in 1955, 39 in 1954, 38 in 1953, and 37 in 1952.

The World Health Organisation's "Health Indicator."

The infant mortality rate, for many years regarded as the most sensitive index of the health and health services of a community, is still a very sensitive index, but—now that the number of infant deaths has become small—is liable to distortion from chance events. For example, in 1935, when 286 Aberdeen babies died (giving a rate of 91), if an extra ten babies had died as a result of an outbreak of measles, there would have been only a slight increase in the infant death rate; but in 1955, when only 66 babies died (giving a rate of 21), an extra ten deaths from a single outbreak would have altered the rate appreciably.

In consequence, various attempts have been made to devise an alternative index. About the beginning of 1957, the World Health Organisation tentatively suggested as such an index the proportion of deaths occurring above the age of 50 years to all deaths.

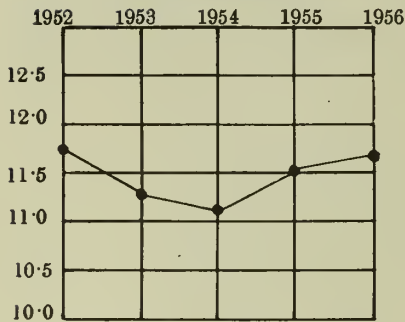
This "indicator" is not wholly satisfactory: if a residential community (with 25 per cent. of its inhabitants of pensionable age) and an industrial community (with only 8 per cent. of its inhabitants of that age) were equally healthy, one would

CITY OF ABERDEEN.

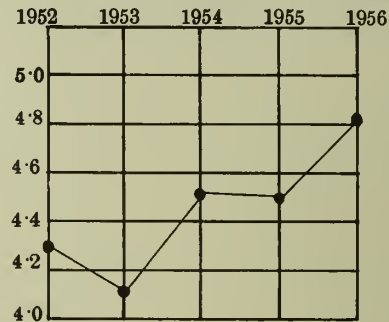
TRENDS OF MORTALITY, 1952-56.

DEATHS PER 1,000 POPULATION.

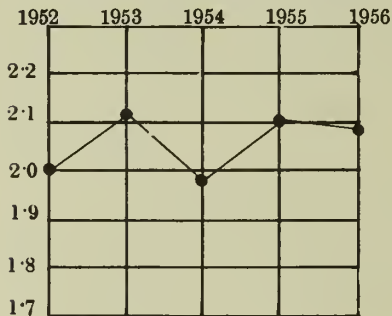
ALL CAUSES.



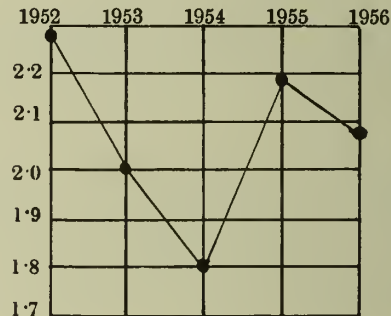
DISEASES OF CIRCULATORY SYSTEM.



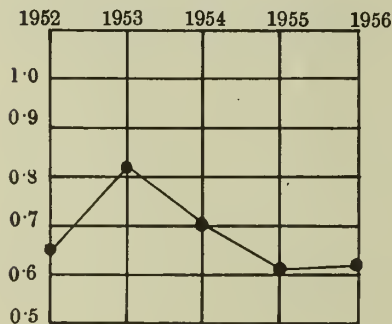
DISEASES OF NERVOUS SYSTEM.



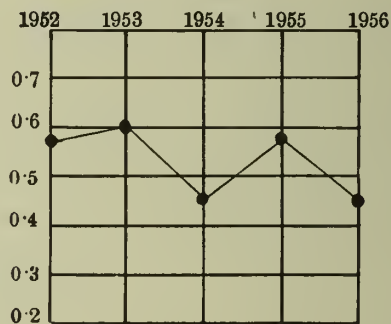
MALIGNANT DISEASES.



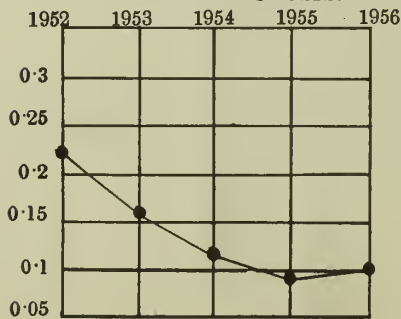
PNEUMONIA AND BRONCHITIS.



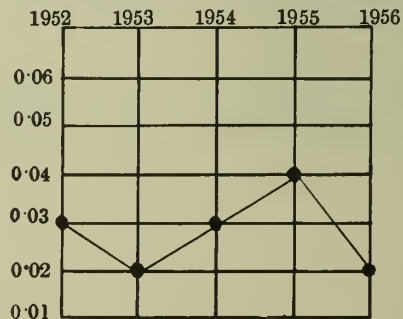
VIOLENCE.



ALL TUBERCULOSIS.



PRINCIPAL EPIDEMIC DISEASES.



expect a far higher proportion of deaths over the age of 50 in the former area. However, for what the figures are worth, here are the data for Aberdeen in recent years:—

Percentage of deaths over age of 50 years to total deaths.

1948 . . .	79.4	1953 . . .	85.9
1949 . . .	83.6	1954 . . .	87.2
1950 . . .	84.2	1955 . . .	88.6
1951 . . .	85.8	1956 . . .	87.9
1952 . . .	84.1		

To such extent as the "indicator" is reliable, it would look as if 1955 had been the healthiest year in the history of the City, with 1956 as the second healthiest year.

Causes of Death.—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 78 per cent. of all deaths fall under three headings—diseases of circulatory system, diseases of nervous system, and malignant diseases. The comparable figures for 1955, 1954, and 1953 were 77, 75, and 72 per cent., respectively.

TOTAL DEATH-RATE.

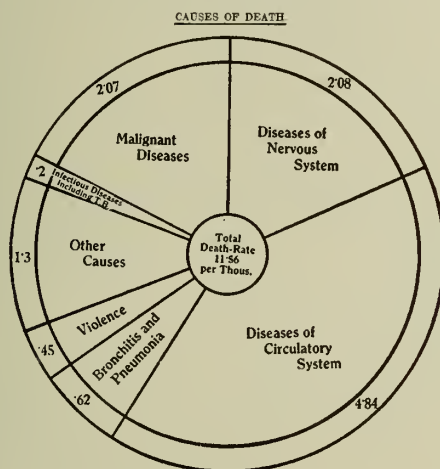


Table III gives, for a number of successive years, the death rates at all ages from selected causes, and Table IV gives, in summary form, details of population, marriages, births, deaths, average age at death, and infant deaths for a number of years and for quinquennial averages.

A diagram illustrates the trends of mortality from various causes in recent years.

LOSS OF WORKING YEARS BY DEATH.

Although study of causes of death and trends of mortality indicates the relative importance of various conditions in respect of loss of life, it does not give a true picture of the effects of different diseases on the community. If, for example, one disease kills thirty persons aged 75-90 years and a second disease kills ten young adults, the second disease is undoubtedly of greater importance to the community, but a study of causes of death would put the emphasis on the first disease.

It is therefore worth while to work out the loss of working years occasioned by different diseases. A convenient hypothesis for such a calculation is that an individual, if not killed by a disease, will work from the age of 15 years to the age of 65 years; so that, for example, if pneumonia causes the death of a man of 61 and a boy of 10 years, the loss of working life is 4 years in the one case and 50 years (an entire working life) in the other. There are, as indicated in the Report for 1955, plenty of minor fallacies; but, on balance, the hypothesis gives a reasonably accurate picture of the effects of various diseases.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1956—

I.—MORTALITY OF PERSONS UNDER 15 FROM VARIOUS CAUSES.

Cause.	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	—	—	—
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	3	1	4
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	—	2	2
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	6	7	13
ii. Bronchitis	1	1	2
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	2	2	4
Diseases of genito-urinary system	1	—	1
Congenital malformations and diseases of early childhood	23	24	47
Violence	17	2	19
Miscellaneous	1	—	1
	<u>54</u>	<u>39</u>	<u>93</u>

II.—APPROXIMATE YEARS OF WORKING LIFE LOST BY DEATHS OF PERSONS UNDER 15.

The working life is taken as from 15 to 65 years of age, *i.e.*, of 50 years' duration for males, and from 15 to 60 years of age, *i.e.*, of 45 years' duration for females.

Cause.	Working Years lost.		
	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	—	—	—
Tuberculosis—i. Respiratory	—	—	—
ii. Other forms	—	—	—
Malignant diseases	150	45	195
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	—	—	—
ii. Other diseases of nervous system	—	80	80
Diseases of circulatory system	—	—	—
Respiratory diseases—i. Pneumonia	300	315	615
ii. Bronchitis	50	45	95
iii. Other respiratory diseases	—	—	—
Diseases of digestive system	100	90	190
Diseases of genito-urinary system	50	—	50
Congenital malformations and diseases of early childhood	1,150	1,080	2,230
Violence	850	90	940
Miscellaneous	50	—	50
	<u>2,700</u>	<u>1,745</u>	<u>4,445</u>

III.—MORTALITY OF WORKING AGE-GROUPS FROM VARIOUS CAUSES.

Cause.	15-24.		25-34.		35-44.		45-54.		55-64.	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Infectious and parasitic diseases (excluding TB.)	1	—	—	—	—	1	1	1	4	2
Tuberculosis—i. Respiratory	—	1	—	1	2	3	2	2	2	1
ii. Other forms	—	—	—	—	—	—	—	—	—	—
Malignant diseases	1	1	2	2	13	10	27	29	54	40
Diseases of nervous system—										
i. Cerebral hæmorrhage, &c.	—	—	1	1	1	1	3	4	20	22
ii. Other diseases of nervous system	1	—	—	—	1	1	3	2	1	—
Diseases of circulatory system	1	—	—	2	10	5	37	23	93	53
Respiratory diseases—										
i. Pneumonia	—	—	—	—	—	1	—	—	3	2
ii. Bronchitis	—	—	—	—	—	—	3	—	9	6
iii. Other respiratory diseases	1	—	—	—	1	—	1	1	2	—
Diseases of digestive system	1	—	—	—	2	1	4	4	9	5
Diseases of genito-urinary system	—	—	2	1	1	—	2	—	4	2
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	—	—	—	—	1	—	—	—	—
Violence	2	1	4	—	6	—	12	5	7	5
Miscellaneous	—	1	2	1	3	—	5	3	11	7
	<u>8</u>	<u>4</u>	<u>11</u>	<u>8</u>	<u>40</u>	<u>24</u>	<u>100</u>	<u>74</u>	<u>219</u>	<u>145</u>
	12		19		64		174		364	

IV.—APPROXIMATE YEARS OF WORKING LIFE LOST BY ADULT MORTALITY
FROM VARIOUS CAUSES.

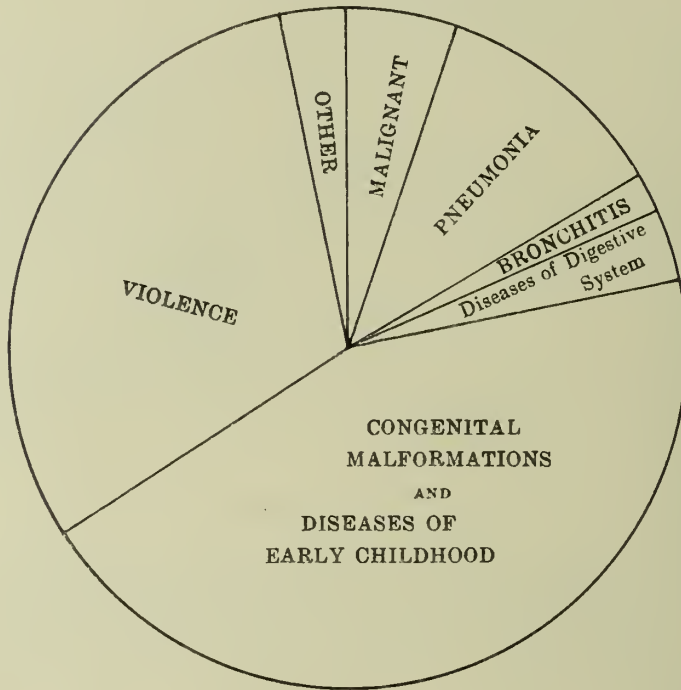
Cause.	Working Years lost.		
	Male.	Female.	Total.
Infectious and parasitic diseases (excluding T.B.)	80	30	110
Tuberculosis—i. Respiratory	90	150	240
ii. Other forms	—	—	—
Malignant diseases	1,115	590	1,705
Diseases of nervous system—i. Cerebral hæmorrhage, &c.	205	90	295
ii. Other diseases of nervous system	120	40	160
Diseases of circulatory system	1,315	390	1,705
Respiratory diseases—i. Pneumonia	15	20	35
ii. Bronchitis	90	—	90
iii. Other respiratory diseases	95	10	105
Diseases of digestive system	200	60	260
Diseases of genito-urinary system	145	30	175
Diseases of pregnancy and childbirth (excluding puerperal sepsis)	—	20	20
Violence	595	90	685
Miscellaneous	275	100	375
	<u>4,340</u>	<u>1,620</u>	<u>5,960</u>

In calculating working years lost by female mortality, the latter age-group 55-64 has been omitted—60 generally being the retiral age for women. A more accurate approximation would be slightly higher than that given.

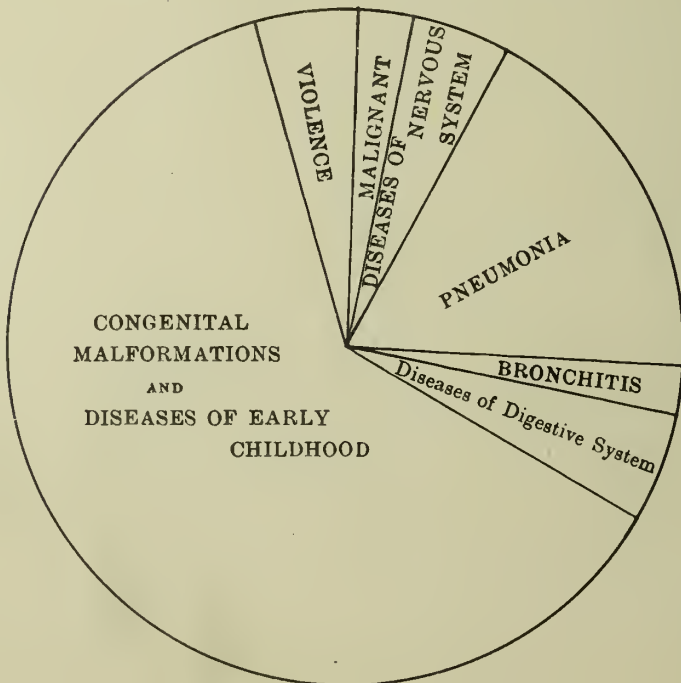
The accompanying diagram illustrates the approximate proportions in each group.

WORKING YEARS LOST BY MORTALITY FROM VARIOUS CAUSES.

MALES—0-15 YEARS.

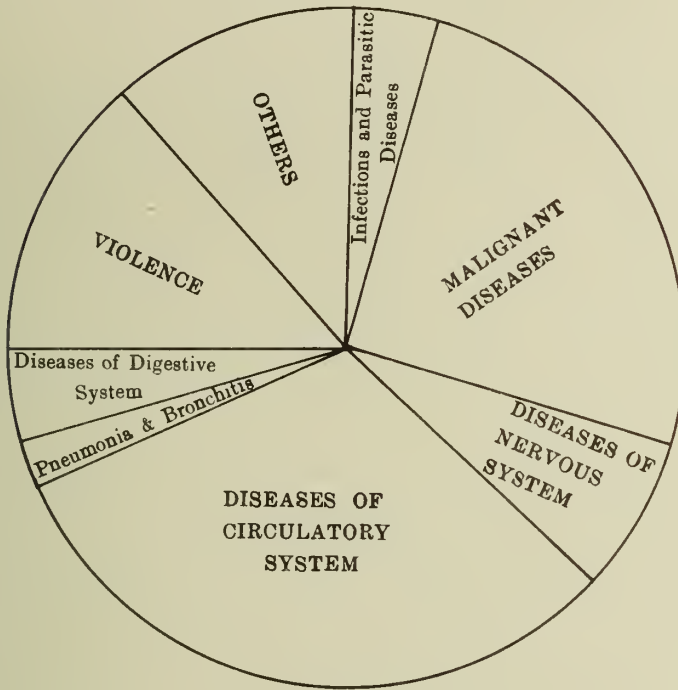


FEMALES—0-15 YEARS.



WORKING YEARS LOST BY MORTALITY FROM VARIOUS CAUSES.

MALES—15-65 YEARS.



FEMALES—15-60 YEARS.

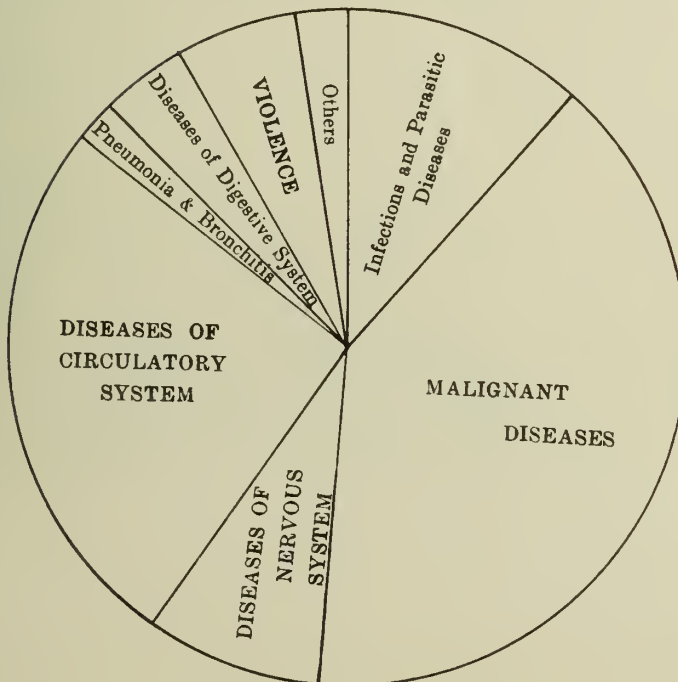


TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.
YEAR 1956.

CAUSES OF DEATH	AGE														
	SECOND TO FIFTH YEARS														
	FIRST YEAR														
	First Four Weeks				First Three Months			The Four Quarters				Total			
	0-1	1-2	2-3	3-4	0-1	1-2	2-3	I	II	III	IV	Total	0-1	1-5	
Tuberculosis	..	..	..	..	..	..	..	..	..	..	..	..	..	0-2
{ Respiratory	..	..	..	..	..	..	..	..	..	..	..	..	..	1
{ Other Forms	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Diphtheria	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Dysentery	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Measles	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Meningococcal Infections	..	..	..	..	..	..	..	..	..	..	..	..	..	0-2
Poliomyelitis, Acute	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Scarlet Fever	..	..	..	..	..	..	..	..	..	..	..	..	..	0-6
Whooping Cough	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Other Infective and Parasitic Diseases	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Pneumonia	..	..	..	..	..	1	2	3	6	2	..	11	0-6	1
Bronchitis	..	..	..	..	..	1	1	1	..	1	2	2	12	1
Diarrhoea and Enteritis	..	..	..	..	..	..	..	..	2	1	1	3	1	0-4
Other Digestive Diseases	1	..	..	..	1	..	..	..	..	..	..	..	2	0-4
Congenital Malformations	..	..	..	2	4	2	6	5	3	..	..	9	11	1
Injury at Birth	5	1	..	..	5	..	9	2	..	..	..	2	19	2
Post-natal Asphyxia and Atelectasis	9	..	..	..	9	..	9	..	..	..	..	..	4	..
Pneumonia of New Born	2	..	..	1	2	..	1	1	..	..	..	1	1	..
Other Infections of New Born	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Other Diseases peculiar to Early Infancy	2	..	..	..	2	..	1	3	..	..	..	3	3	..
Immaturity	16	..	1	..	17	..	..	17	..	..	..	17	11	..
Accidents or other Violence	2	1	..	..	4	1	1	6	1	1	..	8	4	3
Other Causes	1	..	..	..	1	..	..	1	..	..	1	2	4	3
ALL CAUSES	39	2	1	3	46	2	7	55	10	6	2	73	78	14	
Average for preceding 5 years, 1951-1955	44	3	3	1	51	6	4	61	8	5	4	78	..	..

* This column includes all deaths in preceding columns.

TABLE II.—ABERDEEN.—MORTALITY AT VARIOUS AGE PERIODS FROM VARIOUS CAUSES.
(Corrected for transferred deaths.)

AGE.	A.—NUMBER OF DEATHS—YEAR 1956.														B.—DEATH-RATE PER 100,000.										
	All Causes.		Infectious and Parasitic Diseases (excl. Tuberculosis).		Tuberculous Diseases.		Malignant Diseases.		Dis. of Nervous Syst. and Sense Organs.		Dis. of Circulatory System.		Respiratory Diseases.		Dis. of Digest. System (incl. Diarrhoea and Enteritis).		Dis. of Genito-Urinary System.		Dis. of Pregnancy and Child-birth.		Malforms under 1 year and Diseases of Early Infancy.	Senility.	Violence.	Miscellaneous.	
			Principal Epidemic.	Other Infections.	Respiratory.	Other Tuberculous.	Cereb. Hæm., etc.	Other Nervous.	Dis. of System.	Pneumonia.	Bronchitis.	Other Respiratory.	Dis. of System.	Dis. of System.	Puerperal Sepsis.	Other Diseases.									
Under 1 year .	73	—	—	—	—	—	1	—	—	—	—	—	11	2	4	—	—	—	—	—	46	—	—	8	1
1-4 years .	9	—	—	—	—	—	1	—	1	—	—	—	2	—	—	—	—	—	—	—	—	—	—	4	1
5-14 " .	11	—	—	—	—	—	2	—	1	—	—	—	—	—	—	—	—	1	—	—	—	—	—	7	—
15-24 " .	12	—	1	1	—	—	2	—	1	1	—	—	—	—	1	1	—	—	—	—	—	—	—	3	1
25-34 " .	19	—	—	1	—	—	4	2	—	2	—	—	—	—	—	—	3	—	—	—	—	—	—	4	3
35-44 " .	64	—	1	5	—	—	23	2	2	15	1	—	1	—	1	3	1	—	—	1	—	—	—	6	3
45-54 " .	174	—	2	4	—	—	56	7	5	60	—	—	—	3	2	8	2	—	—	—	—	—	—	17	8
55-64 " .	364	—	6	3	—	—	94	42	1	146	5	15	5	15	2	14	6	—	—	—	—	—	—	12	18
65-74 " .	566	1	2	2	—	—	108	125	9	232	11	19	11	19	9	14	9	—	—	—	—	—	—	7	18
75-84 " .	650	3	2	2	—	—	80	147	8	314	20	16	4	16	4	15	17	—	—	—	—	—	—	12	10
85+ " .	213	—	—	—	—	—	16	34	3	132	7	2	3	2	3	1	4	—	—	—	—	—	5	4	2
All Ages .	2155	4	14	18	—	—	387	359	31	902	57	57	22	57	60	43	—	1	—	—	46	5	84	65	
1956 .	1156	2	8	10	—	—	207	192	16	484	31	31	12	31	32	23	—	0.5	—	25	3	45	34		

TABLE III.—**ABERDEEN.—DEATHS AT ALL AGES FROM SELECTED CAUSES.**
(per 100,000 of population).—*Years 1856-1956.**

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Group.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis.		Dis. of Digestive System (inc. Diarrhoea).	Cancer and other Malignant Diseases.	Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
									Respiratory.	Other Tuberculosis.					
1956	0	0	0	0	0	2	0	0	10	0	32	207	31	31	484
1955	0	0	0	1	2	1	0	0	8	1	47	219	26	35	448
1954	0	0	0	0	0	2	0	0	10	2	37	180	27	43	451
1953	0	0	0	0	0	2	0	0	14	2	42	200	26	56	407
1952	0	0	0	0	0	3	0	0	20	2	40	228	31	34	434
1951	0	0	1	1	2	5	0	0	20	3	44	195	38	58	454
Mean of 1951-55 . .	0	0	0·2	0·4	1	3	0	0	14	2	42	204	30	45	439
1950	0	0	0	1	0	7	0	0	20	3	44	208	45	56	434
1949	0	0	0	1	0	5	0	0	32	3	44	182	43	58	414
1948	0	1	0	1	1	2	0	0	33	4	58	169	23	45	361
1947	0	0	0	2	3	1	0	1	35	6	90	177	38	59	402
1946	0	0	0	0	2	5	0	0	40	7	65	175	36	52	390
Mean of 1946-50 . .	0	0·2	0	1	1	4	0	0·2	32	5	60	182	37	54	400
Mean of 1941-45 . .	0	0·4	6	1	3	9	0	0·2	46	16	69	178	42	52	377
„ „ 1936-40	0	1	11	4	7	15	0	1	41	11	69	160	50	73	331
„ „ 1931-35	0	5	9	9	12	18	0	1	52	17	70	159	60	102	276
„ „ 1926-30	0·2	2	10	11	11	21	0	0·2	62	30	78	145	61	100	240
„ „ 1921-25	0	5	11	33	29	27	0	1	88	31	80	140	80	92	195
„ „ 1916-20	0	6	16	22	23	73	0	3	106	43	87	121	99	122	178
„ „ 1911-15	0·2	38	42	56	32	16	0	4	111	49	124	116	101	128	184
„ „ 1906-10	0	6	15	26	42	20	0	2	116	61	115	103	105	116	180
„ „ 1901-05	0·1	8	9	41	47	20	3	4	138	69	162	87	145	125	179
„ „ 1896-1900 . . .	0	23	18	35	53	29	0	9	167	70	210	87	172	109	167
„ „ 1891-95	0·4	21	22	63	52	56	1	10	181	72	190	81	210	100	156
„ „ 1886-90	1	14	10	80	66	9	1	15	184	67	202	68	216	100	175
„ „ 1881-85	0·2	13	15	36	67	1	6	13	204	74	185	69	251	82	159
„ „ 1876-80	1	35	30	28	66	2	19	29	223	101	194	61	286	72	146
„ „ 1871-75	48	68	30	53	68	5	20	35	243	107	214	56	281	60	136
„ „ 1866-70	4	71	35	50	62	8	62	49	298	130	259	59	238	70	122
„ „ 1861-65	36	93	49	51	62	12	176		274	128	280	57	220	59	122
„ „ 1856-60	40	118	54	70	69	12	109		322	179	203	56	182	58	111

*Corrected for transferred deaths in 1904 and subsequent years.

†From 1950 Causes of Death classified in accordance with Sixth Revision of International List of Causes of Death.

TABLE IV.—ABERDEEN—MARRIAGE, BIRTH, AND DEATH RATE—1856 TO 1956.
Per 1,000 of population.

Year	Population†	Marriages		Live Births *			Deaths *			Excess of Births over Deaths	Infantile Mortality Deaths of Infants under 1 year per 1,000 Births
		Number	Rate per 1,000 of Population	Number	Rate per 1,000 of Population	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Population	Average Age at Death		
1956	186,396	1,965	10·5	3,271	17·5	5·3	2,155	11·6	65·9	1,116	22
1955	186,352	1,980	10·6	3,204	17·2	5·4	2,135	11·5	66·7	1,069	21
1954	185,725	1,894	10·2	3,228	17·4	4·3	2,056	11·1	66·3	1,172	22
1953	185,232	1,928	10·4	3,077	16·6	4·5	2,091	11·3	65·1	986	27
1952	183,626	1,929	10·5	3,025	16·5	5·7	2,148	11·7	64·6	877	30
1951	183,248	1,833	10·0	3,028	16·5	5·4	2,181	11·9	65·7	847	27
Mean of 1951-1955	184,837	1,913	10·3	3,112	16·8	5·1	2,122	11·5	65·7	990	25
1950	187,961	1,853	9·9	3,226	17·2	5·3	2,266	12·1	64·9	960	29
1949	189,314	1,841	9·7	3,306	17·5	5·7	2,213	11·7	64·1	1,093	30
1948	188,853	2,104	11·1	3,598	19·1	5·9	2,098	11·1	61·7	1,500	34
1947	187,751	2,091	11·1	4,124	22·0	5·9	2,242	11·9	57·3	1,882	64
1946	176,939	2,186	11·9	3,762	20·4	7·0	2,124	12·0	60·3	1,638	42
Mean of 1946-1950	†	2,015	10·7	3,603	19·2	6·0	2,189	11·8	61·7	1,414	40
1941-1945	+162,687	1,944	10·8	2,901	16·1	8·8	2,172	13·4	57·9	729	65
1936-1940	†	1,962	11·0	2,973	16·7	6·2	2,243	12·7	55·4	730	72
1931-1935	171,959	1,590	9·2	3,133	18·2	7·1	2,284	13·3	52·1	849	86
1926-1930	165,956	1,510	9·1	3,263	19·7	8·2	2,207	13·3	49·1	1,056	94
1921-1925	161,622	1,582	9·8	3,763	23·3	8·2	2,303	14·3	44·4	1,460	115
1916-1920	161,568	1,754	10·9	3,479	21·5	10·6	2,439	15·1	41·7	1,040	127
1911-1915	164,324	1,489	9·1	3,959	24·1	10·2	2,752	16·8	38·1	1,207	143
1906-1910	163,620	1,360	8·3	4,505	27·5	9·7	2,512	15·4	37·6	1,993	128
1901-1905	158,082	1,428	9·0	4,872	30·8	8·5	2,763	17·5	34·9	2,109	143
1896-1900	145,740	1,356	9·3	4,636	31·8	8·3	2,644	18·1	33·3	1,992	144
1891-1895	131,627	1,099	8·4	4,114	31·3	9·8	2,539	19·3	32·9	1,575	147
1886-1890	117,587	911	7·8	3,827	32·5	10·4	2,370	20·2	...	1,457	140
1881-1885	108,959	848	7·8	3,712	34·1	10·6	2,159	19·8	...	1,553	126
1876-1880	100,419	788	7·9	3,480	34·7	10·9	2,100	20·9	...	1,380	129
1871-1875	91,941	705	7·7	3,169	34·5	12·1	2,063	22·4	...	1,106	133
1866-1870	84,234	684	8·1	3,010	35·7	12·9	1,978	23·5	...	1,032	133
1861-1865	77,040	624	8·1	2,663	34·6	...	1,915	24·9	...	748	130
1856-1860	73,458	524	7·1	2,397	32·6	...	1,772	24·1	...	625	126

* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years.

† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

4.—HEALTH EDUCATION.

Some features of 1956 were—

- (1) Members of the staff of the Health and Welfare Department prepared material for the Aberdeen Clean Food Guide (discussed in the chapter on Food Hygiene), and health visitors and sanitary inspectors co-operated in attempts to educate the staffs of various catering establishments in the principles of food hygiene.
- (2) The campaign for the reduction of home accidents (discussed in a separate chapter) was continued.
- (3) There was a further intensification of individual health education of persons of ripe years (and, as mentioned elsewhere in this report, during the year 2,320 persons of pensionable age were visited by health visitors—as compared with 1,238 in the previous year).
- (4) Throughout the year the number of talks on health topics given both at clinics and to pre-formed audiences in the evenings steadily increased.

These features, however, important though they may be, pale into relative insignificance beside the two biggest advances of recent years—

- (a) Full recognition of the rôle of the family health visitor in the teaching of mental and emotional health; and
- (b) the development in the autumn of 1956 of group teaching of prospective parents and young parents on a previously unprecedented scale.

INDIVIDUAL TEACHING—BUILDING ROBUST PERSONALITIES.

(1) The family health visitor as a teacher.

The authoritative report of the Working Party set up by the Ministers of Health and Education and the Secretary of State for Scotland defined the health visitor's primary functions as health teaching and social advice. There are, of course, quite a number of other people who can help with the health education of individuals and families—the public health medical officer, the general practitioner, the clergyman, the district nurse, the midwife, the school teacher, the social worker, the sanitary inspector, and sundry others; but the health visitor has certain profound advantages:—

- (a) She shares with doctors and with other trained nurses a professional knowledge of disease and disease-processes and therefore a certain authority in the eyes of the community.
- (b) Unlike the other individuals mentioned (except the public health medical officer), she has had a considerable full-time training in methods of preventing disease and promoting health;

- (c) Unlike the others (except the school teacher and the clergyman), she has received in her training a good deal of instruction in the arts of teaching and persuading.
- (d) Unlike most other workers, she has access to the ordinary home before any abnormal situation occurs (and in this connection it may be stressed that the time when an individual is ill and the entire household upset is no time to begin the long, laborious task of teaching the basic principles of healthy living).
- (e) Unlike some of the other workers, she is welcomed in practically every home (*e.g.*, in Aberdeen, her visits are accepted by over 99 per cent. of the mothers of young babies and also by over 99 per cent. of elderly persons or elderly couples living alone).
- (f) From her knowledge of the personalities, temperaments, backgrounds, abilities, and interests of the individuals in her district, she should be able not only to adapt her teaching to the individual but also, in many cases, to anticipate the particular health hazards most likely to occur (*e.g.*, she may judge that one young couple, unless suitably guided, will tend to over-discipline their offspring, while another couple will err in the direction of licence, and a third will be prone to inconsistency).
- (g) By reason both of her training and of her experience, she should have an unrivalled knowledge of normality and should be in a position to detect deviations from normality at a stage when they are still imperceptible to less experienced workers.

In view of these assets, she is already generally recognised as the main agent for teaching physical health and hygiene to individuals and families.

(2) The need for a teacher of emotional health.

Diseases of mental and emotional origin constitute a growing menace to our civilisation. Already mental diseases and mental deficiency take up 47 per cent. of the beds provided by Regional Hospital Boards; already neurotic diseases are the commonest cause of absence from work; already an incalculable amount of suffering and distress is created by psychosomatic disorders; and to these can be added a vast number of cases of abnormal and anti-social behaviour—chronic alcoholism, drug addiction, juvenile delinquency, truancy, petty crime, sex perversions, prostitution, &c. "Treatment of a fully developed case of psychoneurosis involves the expenditure of much time and much money. We in Britain have not enough doctors, not enough nurses, not enough hospital beds, not enough money for the effective treatment of even the visible portion of this vast iceberg. Unless we can reduce the prevalence of these conditions by preventive measures, the outlook is dismal indeed."

At least one-half of all human disease and suffering has its origin in faulty human relationships, especially in childhood, and particularly in the formative pre-

school years. Measures designed to improve such relationships are imperative if our civilisation is not ultimately to be swamped by the rising tide of anxiety states, obsessions, depressions, hysterias, sex perversions, delinquency and crime.

To prevent faulty human relationships in the important early years, we clearly need a person to guide prospective parents and parents of young children about the emotional and social needs of children and about the ways of avoiding such dangers as making the child feel insecure or unwanted, failing to demonstrate affection sufficiently, mollicoddling, forcing, repressing, or being guilty of inconsistency in the handling of the child. Manifestly, to advise successfully, the person concerned must have access to the normal home before faulty situations exist and must be acceptable to parents or prospective parents.

(3) Modern and older health visitors.

It is becoming increasingly appreciated that the modern, recently trained health visitor is the member of the community in the best position to undertake individual teaching about emotional and social needs of children. Indications of this appreciation are found, for instance, in a circular issued on 4th December, 1954, by the Secretary of State for Scotland, pointing out, among other things, that the health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health," and that she should receive information about signs of family difficulty from general practitioners, home nurses, hospitals, and schools; in similar statements made in England and Wales by the Minister of Health; and in the stress laid on the work of the health visitor in a detailed study by a London County Council working party (which consisted of public health medical officers, psychiatrists, health visitors, and a psychiatric social worker).

Criticisms of the modern health visitor's competence for this work usually emanate only from people who are unaware of the extent to which the health visitor's training has altered in recent years. The student health visitor of to-day starts her post-qualification training with some rudimentary knowledge both of psychology and of social aspects of disease (these subjects being now included in the general nursing curriculum), and in her health visiting training she has at least thirty formal lectures on mental health (not mental disease), supplemented by case-studies and tutorials; moreover, many other lectures in her training are on subjects allied to mental health work. She also, of course, receives theoretical and practical instruction in teaching methods.

In general, then, the modern health visitor has the knowledge and the teaching skill to help parents to appreciate more fully the emotional needs of children (*e.g.*, the need for a proper balance between over-strictness and licence, and for the measures that can usually prevent sibling jealousy). And she has the necessary access to the home before any faulty situation exists and the necessary acceptance by the persons to be taught.

Apart, however, from the grave national shortage of health visitors, there is the difficulty that health visitors of an older vintage received very little instruction in mental health and social needs during their training, although some of them have become—by reason of vast experience of the problems of normality—good practical psychologists.

(4) Bridging the gap.

Aberdeen's specific contribution has been an attempt to bridge the gap—by providing in 1954 and 1955 intensive post-qualification courses in mental health for older health visitors. By the beginning of 1956 every health visitor in the employment of the Corporation (with three exceptions, two of whom are employed on highly specialised duties) had received adequate instruction in mental health, the younger ones as part of their professional training, and the older ones by attending an intensive course.

As the gaps in the establishment are slowly filled, the health visitors are devoting increasing portions of their time to the teaching of emotional health—to seeking to build robust personalities able to withstand the minor frustrations of life. Their work should in course of time lead to considerable improvement in parent-child relationships and to reduction in such conditions as neurotic diseases, psychosomatic illnesses, juvenile delinquency, and maladjustment. The reduction in the number of cases referred to the child guidance clinic in 1956 may be the first indication of success, or it may be purely coincidental: one cannot hope to evaluate a long-term project in a year or even in several years.

THE HEALTH GUIDANCE SCHEME.

The health guidance project—*i.e.*, provision of group teaching on physical and emotional health on an unprecedented scale—was planned in 1955, was expected to begin at the end of that year or early in 1956, but did not actually start until November, 1956. The scheme was set out fairly fully in the annual report for 1955, but was in a state of indefinite postponement when that report appeared. It may, therefore, be useful to repeat (with condensation or alteration in a few portions) the outline given in the previous report.

(1) The Need for Health Education.

Health education is the most important function of a local health authority, and its importance—both absolute and relative—is increasing year by year. In the era of “environmental hygiene” many improvements in the health of the people were brought about by measures imposed by local authorities without active co-operation by the individual members of the community. For example, the ordinary citizen did not have to take any action (beyond paying his rates) to secure the provision of safe water supplies and proper sewage disposal, with consequent reduction of water-borne diseases. Increasingly, however, further improvements in health are coming to depend on the activity of the citizens as a whole. This is true of most of the remaining infectious diseases: we cannot, for

instance, eliminate food-borne infections without the active co-operation of the individuals who handle food in the shop and in the home; and we cannot immunise or vaccinate children against such diseases as diphtheria, whooping cough, tuberculosis, smallpox, and poliomyelitis unless the parents have become actively aware that inoculation is in their children's interests. It is even more true of non-infectious physical conditions: for example, we cannot do much to prevent domestic accidents unless the average householder is persuaded to pay some attention to home safety. It is true of the health maintenance of the elderly: we cannot preserve or improve the health of elderly citizens unless these citizens both understand the advice offered and are prepared to accept it. It is also true of diseases of mental and emotional origin: to reduce neurotic and psychosomatic disorders by improving the standards of parent-craft and child-care and the serenity of the domestic atmosphere, the interested and active co-operation of parents is an obvious necessity. It is, therefore, of the highest importance to give as many individuals as possible an intelligent appreciation of how preventable diseases are caused, to let people get an insight into the nature of health problems, and to persuade them to adjust their patterns of living to prevent needless illness.

Moreover, health is far more than merely the absence of disease. A person can be listless, dispirited, apathetic, "only half alive," without suffering from any recognisable illness. Health is a condition of physical, mental, emotional, social, and spiritual well-being, a state in which body and mind are functioning efficiently, and in which the individual is correctly adjusted to all factors in his environment. The promotion of health as well as the prevention of disease can be achieved only by health education.

The National Health Service in Britain costs £600,000,000 a year, three-fifths of the money being spent on the hospital treatment of disease and injury. Sickness benefit costs another £90,000,000 annually, and about 200,000,000 working days are lost each year through illness. These losses of money and time are bound to continue until preventive measures reduce the incidence of sickness; but already a goodly number of diseases and injuries are recognised as preventable. The main available method of prevention is health education. Various local health authorities have therefore created Health Education Sections in their Health Departments, and the Chairman of the Sheffield Health Committee appropriately summed up the financial aspects in his presidential address to the Royal Society of Health in 1954:

"I believe that money provided for health education is a sound social investment, which will yield rich dividends in the social well-being and happiness of the people."

(2) Varieties of Health Education.

All health education aims at the acceptable presentation of knowledge which will help to improve physical or mental health.

Probably the commonest misconceptions about health education are that it is simple and that it consists mainly of group-teaching. The misconception about simplicity is due to the early emphasis on the simple things necessary to prevent

food-borne infections—hand-washing, physical cleanliness, &c. Actually, if one considers such aspects of health teaching as the rectification of the attitude of a mother who is over-protecting a delicate child or who is expecting from her three-year-old the behaviour standards of a child of four, or the convincing of a man previously engrossed with his work that he ought to cultivate hobbies in preparation for his retirement, it soon becomes obvious that health education (far from being simple) is about the most complex subject in the whole range of the medical and biological sciences.

As for group-teaching, while it is a valuable adjunct to individual health-teaching, it cannot as a rule be more than a supplement. Health Weeks, Health Sundays, Health Exhibitions, Parents' Clubs, Classes for Expectant Mothers, Public Lectures, and so forth are of relatively little use by themselves, although they can be of the highest value when employed to reinforce the work of the individual health teacher in the home.

(3) Individual Health Teaching.

The education of individual persons and individual families in their own homes is the primary task of the district health visitor, supplemented by other health workers. It is of basic importance, because the health visitor knows the personality, temperament, interests, abilities, and social and educational background of the individual, and can adapt her teaching to the particular needs and capacities of the person taught.

Individual health teaching comprises a large part of the work of health visitors and departmental medical officers. The family health visitor in the home advising on the immunisation of the baby or the behaviour difficulties of the toddler or the preparation for retirement by the elderly persons, the health visitor guiding the family as a whole towards a better integration with their environment (in the wider sense of that word), the doctor at the child welfare clinic advising an individual mother about the physical or emotional problems of her child, the doctor at the antenatal clinic discussing with an expectant mother the hygiene of pregnancy, the health visitor at the same clinic discussing the emotional re-adjustments that will be necessitated by the birth of the child, the school doctor or school health visitor inculcating the idea of health maintenance as part of one's duty to oneself and to the community, the district nurse or the sanitary inspector or the home help striving in the case of an individual household to remove factors prejudicial to health—these are the various people who do most of the effective health education teaching. The family health visitor has, inevitably, the main rôle: she has more training in health teaching than has the departmental medical officer, and she has the tremendous advantage of free access to the homes.

In Aberdeen, the vital rôle of the family health visitor in health teaching has been recognised: the establishment has been increased to 85 health visitors (or 1 per 2,200 total population), and efforts—at present unfortunately unsuccessful—are being made to secure, over a series of years, the necessary staff to fill the vacancies.

The existing district health visitors already undertake much individual health education, and attempts are being made—by study days, &c.—to equip them more fully for this work.

For the most complicated but also the most needed form of individual health teaching, education in mental health, it has been appreciated in Aberdeen that the health visitor not only possesses unique qualifications—unrivalled knowledge of normality, training in the art of persuading, entry to the home before any faulty situation exists, intimate knowledge of the family, and, in the eyes of the family, the authority conferred by her triple training as nurse and midwife and health visitor—but is about the only person in the community who is competent to undertake this teaching. Accordingly, the better to enable health visitors to cope with the teaching of mental health, post-qualification courses were conducted in 1954 and 1955.

(4) Group Health Teaching.

Although unsatisfactory when employed alone, group health education can form a most useful supplement to individual teaching in the home and in the clinic. The formal lecture, the informal talk, the open forum, the discussion group, and the health exhibition all have their place in the work of a modern health department.

Group health education is perhaps best considered under two heads, systematic and sporadic.

An example of systematic group teaching is the setting up of mothers' clubs or parents' clubs, with a series of weekly meetings, perhaps devoted in one term to a discussion group on the emotional development of children, in another term to discussions on accident prevention, and in a third to the preparation of a small health exhibition. Another example is the organisation of a course of talks for prospective parents. An attempt in 1955 to increase the previous small number of talks given at child welfare clinics suggested that very considerable expansion of these talks would be possible in the future—particularly if they were re-organised, well co-ordinated, and supported by films, film-strips, models, flannelgraphs, charts, &c.

Under the heading of sporadic group health teaching may be mentioned occasional talks or discussions at Church Guilds, Co-operative Guilds, Youth Clubs, Parent-Teacher Associations, Old People's Clubs, and so forth. During 1955 and 1956 several members of staff, and in particular the two health visitor tutors, gave generously of their leisure time in an attempt to develop sporadic health teaching. The success of these efforts made it obvious that, if sufficient speakers were available, there would be a very considerable demand for health talks.

(5) Varieties of Health Guidance Sections.

It was obvious, as mentioned above, that some expansion of systematic health education and considerable expansion of sporadic health talks had been achieved so easily that, if suitable personnel became available, very considerable further

expansion would be possible. It was also obvious that such expansion would be very much in the interests of the community.

It was also clear, however, that any appreciable development of group health education would involve a very considerable amount of highly skilled work. The actual giving of health talks and leading of discussion groups would involve skills analogous to those required for further education work of an advanced type; and the preparation of suitable leaflets, the selection of appropriate films and film-strips, the arrangement of interesting and informative programmes of systematic instruction, the selection of demonstration material, the allocation of speakers to audiences, and the general co-ordination of the work would call for considerable administrative and organising capacity and would also consume much time. Broadly, it was realised that the people undertaking the work would require such talents and skills as—adequate technical knowledge of health matters, ability to select appropriate points, ability to lead community projects, adequate training in methods of imparting information to different types of audience, skill in public speaking, knowledge of some of the commoner aids to teaching, some knowledge of the interests and abilities of the people to be taught, and—in the persons responsible for the organisation and administration of the scheme—balanced judgment, organising power, and ability to delegate.

When the Health and Welfare Committee considered the creation of a health guidance section, it appeared that three separate patterns of health education lecturers had been evolved elsewhere—

(A) *Medical officers for health education*, generally assisted by less highly qualified officers and appropriate clerical staff. Disadvantages of this pattern were that medical officers have a more detailed training in the diagnosis and treatment of diseases than is strictly necessary for health guidance lecturers; that it is very difficult to find medical officers with the requisite knowledge of teaching methods; and that outstanding public health medical officers with organising ability and experience of teaching would be unlikely to seek employment in health education posts where their separation from other aspects of public health work would impair their chances of promotion.

(B) *Trained teachers* (e.g., with degrees in biology) with some subsequent training in health matters, with appropriate clerical assistance. Disadvantages of this pattern were that advanced further education work in any field demands considerable specialised knowledge on the part of the teachers; that no short course of instruction in health matters could provide sufficient information about the processes of physical and mental disease and the principles of the promotion of physical, emotional, and social health to convert the individuals into experts competent to teach others; that, once health education had passed beyond its simplest and most elementary phases, teachers with neither medical nor nursing backgrounds might possess no more knowledge of their subject than some members of their audiences; and that teachers with sufficient persuasive power to interest audiences that were

free to depart and with sufficient organising power to take charge of health education would be unlikely to accept "dead end" jobs in a health and welfare department, since their qualities would be such as to mark them out for high promotion if they remained as school teachers.

(C) *Specialist health visitors*, with appropriate clerical assistance. This in many ways appeared to be the most satisfactory of existing patterns. Health visitors, by their training and experience, acquire adequate knowledge of disease-processes and of the implications and ramifications of disease, unrivalled knowledge of normality and its problems, an outlook oriented to prevention, skill in individual health teaching, and some training and experience in group health teaching: they have, in fact, an excellent background for health education lecturers. Moreover, because promotion prospects are very much poorer in health visiting than in medicine and teaching, outstanding health visitors are much more likely to accept posts as health education lecturers than are outstanding doctors and teachers. In this connection, it could be noted that one of the most successful ventures in health education is that of Buckinghamshire, where two selected health visitors are employed full-time on health education (at extra remuneration) and that the appointment by the National Association for the Prevention of Tuberculosis of a selected health visitor as their lecturer has again been outstandingly successful.

(6) The Health and Welfare Committee's decision.

It appeared to the Committee that, while the third pattern mentioned above was probably the most satisfactory of existing patterns, several points merited consideration—

(a) Most health visitors, however carefully selected for health education work, would benefit from the occasional advice and guidance of someone with more training and experience of actual teaching.

(b) The arrangement of having two officers working full-time on group health education might not be ideal; if, instead, a number of officers devoted part of their time to group teaching and the rest of their time to health visiting, they would retain their personal contact with individual families and their active awareness of the problems and difficulties of the people. Moreover, the scheme would acquire greater flexibility: *e.g.*, if experience in three separate districts showed that the best times for health meetings were Tuesday nights and Wednesday afternoons, these requirements could be met, whereas, with two full-time lecturers, it would be necessary to allocate Monday evenings and Thursday mornings to one of the districts.

(c) While a health visitor has a very good background for health education work but has rather inadequate training in group teaching, and while a school teacher has a good training in group instruction but lacks knowledge of health principles and disease processes, a health visitor tutor combines the advantages of both. The background of any qualified health visitor tutor is—a good general education, a general nursing training, a training in midwifery, a period as hospital

staff nurse or ward sister, a health visitor's training, some years as a practising health visitor, a year of full-time teaching training for the tutor's certificate, and subsequent experience in the teaching of student health visitors. This surely is the ideal background for a health education lecturer.

(d) The Corporation at present has as its Principal Health Visitor Tutor a tutor of quite outstanding calibre (as evidenced, for instance, by awards and distinctions gained both before her appointment to Aberdeen and subsequently) who possesses to a very high degree all the skills and qualities required for a health education lecturer and organiser; and in the present Assistant Health Visitor Tutor the Corporation has again been fortunate in securing an outstanding officer admirably fitted to undertake group projects and group education. Moreover, the tutors have already demonstrated, mainly in unpaid work performed during the evenings, their abilities both as lecturers and as organisers: the success of the Home Safety Week in 1954, for example, was in large measure attributable to their efforts.

The Health and Welfare Committee therefore decided to entrust the work of health guidance to seven persons, each devoting only a portion of her time to the subject. The seven persons were the two tutors (to be given some additional remuneration in respect of their additional duties—largely outside normal working hours—both as health guidance lecturers and in the organisation and administration of the health guidance section), and five selected health visitors (to be designated Senior Health Visitors, to be relieved of ordinary health visiting duties for about two afternoons weekly, and to receive an additional £75 annually in recognition of group teaching undertaken during normal working hours and on certain evenings).

When the proposal was submitted to the Secretary of State for Scotland, he declined to approve the portion relating to the additional payments for the five health visitors, on the ground that such payment might be regarded as determining the amount of additional salary to be paid to a promotion grade of Group Adviser (advocated by the Working Party on Health Visiting) in advance of any decision by the appropriate Whitley Council. However, a number of health visitors generously volunteered to take part in the scheme without any immediate payment, on the understanding that, if the proposed grade of Group Adviser came into being, the individuals selected for the health guidance work would be among the first Aberdeen health visitors considered for appointment to the new grade.

(7) The Start of the Project.

In November, 1956, the scheme was launched, with very favourable press publicity, one of the local daily newspapers christening it the "thousand salvo blitz on disease" (because the estimated number of health talks in a single year was a thousand). By the end of the year eight courses of weekly talks for expectant mothers were being given at various ante-natal clinics, the first Parents' Club (with weekly evening talks and discussions on health topics) had begun to run smoothly, a second Parents' Club was just starting and a third was being planned, the number of health talks given at child welfare clinics had risen considerably, and requests

for talks were beginning to arrive in considerable numbers from church guilds, co-operative guilds, and other organisations. By 31st December four points were clear—

- (a) that the public were prepared to attend health meetings (a point that became even more manifest after the end of the year);
- (b) that the requests for sporadic talks were even more numerous than had been anticipated (although, in point of fact, the requests that arrived in December were a mere trickle by comparison with the flood of requests afterwards);
- (c) that the organising work and the preparation and selection of appropriate demonstration material were tasks even heavier than had been expected; and
- (d) that, while it was likely that the total number of health talks in a complete year would be in the neighbourhood of the thousand previously forecast, the limiting factor would be the working capacity of the health guidance team rather than the amount of demand by the community.

5.—PREVENTION OF HOME ACCIDENTS.

During 1956, the campaign against home accidents continued on the same lines as in 1955.

Need for Preventive Measures.

Domestic accidents are still nationally (and were also locally until 1954) one of the leading causes of death and disability in children, and a frequent cause of death or disablement at the upper end of life. Indeed, as has often been stated publicly, home accidents cause more deaths in Britain than do road accidents.

Essentially, however, the causes of home accidents can be investigated by ordinary epidemiological techniques, and the well-tried methods of health education can usefully be applied to the problems of accident prevention.

Home Safety Campaign.

The Corporation's campaign for the reduction of home accidents has now extended over three years. The campaign can best be described under four headings:

(1) *A Home Safety Week.*—To focus the attention of the people not only on the frequency of home accidents but also on the fact that many accidents were preventable, a home safety campaign was organised in the spring of 1954 and conducted with maximum publicity. The Aberdeen Home Safety Week was the first of its kind, although London and Stirlingshire organised similar weeks a few months later. Incidentally, the total cost was only £208, or less than the cost to the community of two serious accident cases each treated in hospital for seven weeks at £15 a week,

(2) *Work in the Homes*.—From 1954 onwards, the health visitors and other health workers have quietly but persistently pointed out potential causes of accidents. While group teaching (which underwent great expansion in 1956) has been useful, it must be recognised that the most effective agent for accident prevention is the family health visitor in the privacy of the home.

In this connection it may be worth while to point out that, if, during a whole year, a health visitor prevents four serious accidents (each of which would have required seven weeks of hospital treatment) and four milder accidents (each of which would have necessitated a fortnight in hospital) then—even if she does no other work—she saves the community more than her total salary, in addition to saving much needless suffering.

(3) *Booklet on Home Safety*.—As a supplementary measure, an illustrated booklet on Home Safety was produced (early in 1955) without any cost to the Corporation, and distributed—free of charge—at the clinics and by health visitors.

(4) *Research into accidents*.—Since it soon became obvious that, while sufficient knowledge already existed to render a considerable reduction of home accidents possible, there remained many gaps in that knowledge—gaps that could be rectified only by specific detailed investigation whether conducted in Aberdeen or elsewhere—the writer, with the consent of the Corporation, applied as an individual to the Nuffield Trust for a research grant for the investigation of home accidents. The application was granted (in 1955), a sum of over £1,300 was provided, a specialist health visitor was appointed for research work (paid by the Nuffield Trust), the hospitals and over forty general practitioners agreed to notify all cases of home accidents coming to their notice, all the health visitors undertook to notify all cases that became known to them, a detailed record card was devised, and the investigation began in the autumn of 1955.

Results.

The home safety campaign has already begun to produce results; in particular, there has been a sharp decrease in the number of home accidents in elderly people, and in the age-group 1-15 years there has been only one death due to a home accident in a period of three years.

According to the Registrar-General's figures, there were in 1956 34 Aberdeen deaths attributed to home accidents.

6.—MATERNITY AND CHILD WELFARE.

Some salient features of the year were—

- (1) The Corporation's first purpose built clinic was opened at Holburn early in the year, and the second, at Northfield, was opened in the middle of 1956.
- (2) The number of women attending the ante-natal clinics and the total number of attendances at these clinics were a shade below the corresponding figures for 1955 (which were by far the highest figures ever recorded) but were satisfactorily high, the number of women attending during the year approximating closely to the total number of births.
- (3) The number of women attending post-natal clinics and the number of attendances at these clinics were even higher than in 1955, although the figures for that year had been higher than ever before.
- (4) The number of babies under one year attending child welfare clinics and the number of attendances by babies at these clinics were even higher than in 1955.
- (5) The number of children aged 1-5 years attending child welfare clinics and the number of attendances were higher than in 1955, although the figures for that year were higher than ever before.
- (6) The number of women attending the gynæcological advisory clinic and the number of attendances constitutes further new high records.
- (7) The follow-up of expectant mothers found to be anæmic, begun in 1955, was intensified.
- (8) Relaxation exercises were made available for expectant mothers.
- (9) By far the biggest developments of the year were a considerable enlargement of facilities for instruction of prospective parents in parentcraft and the provision of talks for parents on physical and emotional health.

(a) EXPECTANT AND NURSING MOTHERS.

(i) Ante-Natal Clinics.

In continuation of the policy of decentralisation (taking the service to the public instead of making the public travel appreciable distances to the service), four new weekly ante-natal sessions were provided—two at Holburn Clinic and two at Northfield Clinic. These, in turn, eased the pressing load at the central ante-natal clinic at Castle Terrace and allowed more time for adequate health teaching and medico-social investigation.

At a glance, it must look as if the Corporation conducts only thirteen weekly ante-natal sessions, but actually four of these are treble sessions (*e.g.*, with three doctors present) and five are double sessions, so that the total is equivalent to twenty-five single weekly sessions.

Every effort is made to encourage the attendance of expectant mothers at these clinics, which provide obstetrical and medical supervision, instruction in the health and hygiene of pregnancy, advice about the needs of the family during the confinement, information about allowances and welfare foods, and instruction in parent-craft, including the physical and emotional health of the child. In particular, women for whom institutional confinement has been arranged—approximately 85 per cent. of all expectant mothers in the City—attend the clinics. Of the remaining 15 per cent. who are under the care of general practitioners and/or municipal midwives, a few also attend the clinics for specialist consultation and health teaching; so that, in all, fully 90 per cent. of expectant mothers attend the clinics—a highly satisfactory total.

In the clinics, the co-operation of hospital consultants and midwives on the one hand, and of medical and health visiting specialists in health matters on the other hand, ensures that the best practicable advice is offered both on clinical and on medico-social points; and the unusually high percentage of expectant mothers attending the clinics is undoubtedly causally related to the low still-birth rate, maternal death rate, and neo-natal death rate obtaining in the City during recent years.

At the close of the year, the distribution and medical staffing of the sessions were—

Castle Terrace—4 sessions—staffed by 1 consultant, 1 assistant medical officer of health, and 1 junior medical officer.

Castle Terrace—1 session—staffed by 1 consultant and 1 junior medical officer.

Castle Terrace—2 sessions—staffed by 1 consultant. Primarily for research into problems of pregnancy.

Holburn—1 session—staffed by 1 registrar and 1 assistant medical officer of health.

Holburn—1 session—staffed by 1 assistant medical officer of health.

Northfield—1 session—staffed by 1 consultant and 1 assistant medical officer of health.

Northfield—1 session—staffed by 1 assistant medical officer of health.

Torry—1 session—staffed by 1 assistant medical officer of health and 1 registrar.

Hilton—1 session—staffed by 1 assistant medical officer of health and 1 registrar.

At each session, health visitors are present in addition to the hospital and local authority medical staff. At the main centre (Castle Terrace), student midwives attend under the supervision of a midwife, and a receptionist and clerkess are also present. To prevent undue waiting, an appointments system is in operation at all clinics.

When an expectant mother visits a clinic for the first time, she is promptly interviewed by a health visitor, who allays fears and anxieties, explains the routine of the clinic, and records necessary particulars. The patient is then physically examined by one of the medical staff and is given an appointment for her next visit.

As a rule, samples of blood are taken from every patient for two purposes—performance of the Wassermann test and measurement of hæmoglobin. Until fairly recently, a specimen of blood was examined for the Rhesus factor in the following cases:—

- (a) all parous women without a previous live child;
- (b) all parous women with a history of blood transfusion; and
- (c) all third pregnancies and over.

During 1955 and 1956, however, the blood of all women attending the clinics has been tested for the Rhesus factor, and, in addition, there has been an intensive follow-up of women found to be anæmic.

Relaxation Exercises.—Towards the end of the year a physiotherapist joined the staff of the department and it became possible to offer courses of relaxation exercises to expectant mothers. The response indicated that this service was welcome but obviously too short a time has elapsed for success to be assessed.

(ii) Post-Natal Clinics.

A specialist post-natal clinic is conducted each week at the Aberdeen Maternity Hospital and, in addition, post-natal clinics are held weekly at Castle Terrace (Monday morning), Holburn (Thursday afternoon), Hilton (Thursday afternoon), Northfield (Tuesday afternoon), and Torry (Monday afternoon) Child Welfare Centres. At the clinic at Castle Terrace, a consultant, an assistant medical officer of health, and a resident medical officer are in attendance, while, at Hilton, Holburn, Northfield, and Torry, there are an assistant medical officer of health and a registrar who examine both post-natal and ante-natal cases during the weekly session.

(iii) Teaching of Parentcraft.

At all the ante-natal and post-natal clinics (and also at child welfare clinics) health visitors give advice on parentcraft. For more systematic instruction a special clinic session has for some years been held once a fortnight at the Castle Terrace Centre. A large scale development, introduced at the end of 1956, was courses of nine meetings held on successive weeks. At the end of the year eight such courses were being conducted—four at Castle Terrace, two at Northfield, and two at Holburn. For further information see the chapter on Health Education.

(iv) Attendances at Ante-Natal and Post-Natal Clinics.

The table below shows the numbers attending and the number of attendances made at the ante-natal and post-natal clinics during 1956, with, for comparison, similar figures for 1955, 1954, 1953, and 1952. It will be noted that the number of women attending the ante-natal clinics approximates closely to the number of births during the year. It will also be noted that the numbers attending and the total number of attendances at post-natal clinics have increased in 1956 to figures higher than in any previous year.

		ANTE-NATAL CLINICS.		POST-NATAL CLINICS.	
		No. of Women.	No. of Attendances.	No. of Women.	No. of Attendances.
1956	. .	3,217	21,919	3,495	5,696
1955	. .	3,451	22,721	2,966	5,113
1954	. .	3,316	22,037	2,381	4,647
1953	. .	3,392	21,081	1,763	2,098
1952	. .	2,874	21,237	1,786	2,065

(v) Gynæcological Advisory Clinic.

This clinic is held at the Castle Terrace Centre, where a specially trained health visitor is in attendance from 9 a.m. to 5 p.m. from Monday to Friday. On Monday and Tuesday mornings and on Wednesday afternoon a departmental medical officer is also in attendance. The number of mothers to avail themselves of the facilities of the clinic during the year was 1,547, and they made 3,124 attendances (as compared with 1,162 and 2,976 in 1955, 671 and 2,702 in 1954, and 632 and 2,607 in 1953).

(vi) Supply of Maternity Outfits and Layettes.

Maternity outfits are supplied free of charge to all women who are being confined at home. The contents of the outfit are in accordance with the suggestions of the Department of Health for Scotland.

Wherever possible, mothers are encouraged to provide their own layettes, but a layette is supplied free in exceptional circumstances. In certain cases, mothers are given wool to make garments for the baby. Where a mother is entitled to receive Maternity Benefit, a charge of not less than £2 is made for a complete layette.

(vii) Arrangements for Care of Unmarried Mothers.

(i) *Aberdeen Mother and Baby Home.*

For a number of years the Corporation have had a standing arrangement with the Aberdeen Mother and Baby Home, Richmondhill House, King's Gate, which is conducted by a voluntary association. Under this arrangement, accommodation is provided for expectant unmarried mothers, and the Corporation pay fifty-two shillings and sixpence per week towards the maintenance of each woman whom they send to the Home. The women may be admitted and discharged at any time, but the Corporation's responsibility is limited to a period of six weeks before the expected date of confinement and four months thereafter. Women are not confined at the Home but at the Maternity Hospital. During the year, the Corporation accepted responsibility for sixteen women admitted to the Home.

(ii) *Salvation Army Homes.*

Arrangements have also been made under which certain expectant unmarried mothers are sent by the Corporation to Salvation Army Homes in either Dundee or Glasgow. The payment made by the Corporation is 14s. per week for six weeks before the expected date of confinement, and 24s. per week for four months thereafter. During the year, one woman was sent to a Salvation Army Home.

The total number of illegitimate births for the City during the year under review was 172, as compared with 172 in 1955, 140 in 1954, 138 in 1953, and 172 in 1952.

(b) CHILD WELFARE.**(i) Child Welfare Centres.**

Three general points may first be mentioned—

- (a) The scope of a child welfare clinic has widened appreciably, and now includes far more than just advice on physical health.
- (b) As in most other areas, the public demand for child welfare clinics is continuing to increase: the total number of children attending clinics has increased each year from 1952-1956.
- (c) The development of new housing areas on the periphery of the town is making the provision of peripheral clinics a continuing necessity.

With the opening of new purpose-built clinics at Holburn and Northfield, there are now twelve child welfare centres in the City, apart from the mobile unit which operates in seven areas. Most of these are full-time, being open daily from 9 a.m. to 5 p.m. with health visitors constantly in attendance, so that mothers may come at any time for skilled advice. At all clinic sessions, where a doctor is in attendance, vaccination against smallpox and immunisation against diphtheria, whooping cough, and tetanus are carried out. Clinic sessions are also held for baby-weighing and advice about the care of children. Special morning sessions are reserved for advising mothers on infant feeding. For the examination of children by the medical staff, an appointments system is in operation and functions satisfactorily, thus saving mothers needless waiting.

Weekly clinics are held at four centres, viz., Seaton Community Centre, Powis Community Centre, the Lads' Club, Gallowgate, Craigiebuckler, and Nigg. A consultant or a registrar from the Aberdeen Hospital for Sick Children attends the Craigiebuckler Clinic weekly.

At Hayton, a clinic is conducted thrice weekly.

(ii) Mobile Health Unit.

A mobile unit has now been in operation for over four years. The unit—the first used for child welfare work in any town in Scotland—was specially designed to provide facilities for medical examination and for immunisation and vaccination in the minimum amount of space.

It is staffed by a departmental medical officer and a health visitor. There is also a driver who, after uncoupling the unit from the van which tows it, is available for other duties while the unit is operating at any one point.

By the end of 1956, the clinic was operating in seven areas as follows:—Kaimhill (Monday afternoon), Mastrick Church Hall (Tuesday morning), Smithfield (Tuesday afternoon), Castlehill (Wednesday morning), Seaton (Wednesday afternoon), Inverdee (Thursday morning), and Stockethill (Thursday afternoon).

While the mobile unit is of tremendous value in providing facilities for skilled examination and advice for parts of the town that are in process of becoming built

up, it will be appreciated that it cannot cope with the needs of a densely populated area to anything like the same extent as a purpose-built clinic.

(iii) Attendances at Child Welfare Clinics.

The number of children who attended the child welfare clinics during the year, and the number of attendances were as follows:—

Total number of children under 5 years of age who first attended at the clinics during the year—

(a) Under 1 year of age, 2,560; (b) over 1 year of age, 4,203.

Total number of attendances made by children during the year—

(a) Under 1 year of age, 23,000; (b) over 1 year of age, 17,431.

As mentioned earlier, the total number of children attending is greater than ever before.

(iv) Facilities for Consultant Advice.

Clinical consultants do not attend at any of the Child Welfare Centres, which are regarded essentially as “well baby” clinics. If any condition is found on which expert clinical advice is required, the mother is told to take her child to her general practitioner, who is advised of the condition, and may, thereafter, seek the advice of an appropriate consultant. The system works reasonably satisfactorily.

(v) Ultra-Violet Light Clinics.

On the recommendation of an assistant medical officer of health, debilitated children can receive ultra-violet light treatment at clinics which are held for that purpose twice weekly at the Charlotte Street, Hilton, and Torry Centres.

(vi) Orthopædic Clinics.

An arrangement has been made with the Principal of the Dunfermline College of Physical Training whereby the Corporation's medical staff may send children suffering from postural defects to a clinic held in the College at Woolmanhill, where remedial exercises are given. This arrangement, in addition to being highly beneficial to the children, is very useful to students.

Pre-school children suffering from other orthopædic defects are referred to an orthopædic clinic which is also now held at Woolmanhill. The children attending this clinic are examined by an orthopædic surgeon from the North-Eastern Regional Hospital Board.

(c) CARE OF PREMATURE INFANTS.

All premature babies born at home are forthwith transferred to the special ward at the Royal Hospital for Sick Children. This enables such babies to secure skilled medical attention and continuous nursing, and gives them the best chance of survival. When it is considered that the babies can safely be sent home, the Health and Welfare Department is notified, and the appropriate health visitor immediately visits the home to ensure that everything necessary is done for the baby.

In certain instances, equipment, such as cots, cot blankets, &c., is issued on loan, and the health visitor gives special instruction to the mother on the care of the baby.

(d) SUPPLIES OF WELFARE FOODS.

During the year, for lack of better premises, a portion of the child welfare clinic at Castlegate was utilised as the main centre for issue of welfare foods. In addition to welfare foods supplied at each child welfare centre, Vitamins A and D liquid (Adexolin) is distributed free of charge to necessitous cases. One outstanding feature of the distribution of welfare foods is the number of shopkeepers in the various peripheral housing areas who have offered to sell welfare foods. This has proved a boon not only to the residents in the area but also to the local authority, as the shopkeepers undertake this work on a purely voluntary basis. Certain proprietary milk foods are also issued at reduced prices at the discretion of the departmental medical officer at each clinic.

The amount of welfare foods issued to the public during December of 1954, 1955, and 1956 was as follows:—

		National Dried Milk. Full Cream. Half-Cream.	Cod Liver Oil.	Vitamins A & D.	Orange Juice.	
December, 1954	.	6,482	488	1,987	523	8,137
December, 1955	.	7,539	628	2,160	823	10,775
December, 1956	.	7,945	496	1,860	708	12,348

The figures for December, 1953, *i.e.*, when the sale of the foods was undertaken by the Ministry of Food, are not available, so, unfortunately, a comparison cannot be made with the sale of foods in December, 1953.

(e) DENTAL CARE.

Out of an authorised establishment of seven dental officers, the number employed throughout the year was three full-time and one part-time.

Despite the severe shortage, the present dental staff managed to undertake more work than in previous years (excepting 1955) for expectant mothers and young children referred to them by the medical officers at the ante-natal and child welfare clinics. The following figures show the work which the dental officers undertook during recent years:—

	Examined.			Found to need Treatment.			Treated.		
	1956.	1955.	1954.	1956.	1955.	1954.	1956.	1955.	1954.
Expectant and nursing mothers	36	12	—	36	11	—	30	10	—
Pre-school children ...	324	464	137	265	270	78	197	136	51

(f) PREVENTION OF BREAK-UP OF FAMILIES.

Before the Department of Health for Scotland had issued Circular 77/1954, the Corporation had already accepted that (in the phrasing of that circular) the health visitor's work "now extends to cover the whole field of prevention of ill-health, including prevention of mental ill-health." The Corporation has deliberately

made no effort to secure either a social worker with special training or a health visitor with special training, but has preferred to tackle the problem of prevention of break-up of families by (i) extending its establishment of health visitors so that each health visitor would have adequate time available for "problem" and "border-line" families in her district, and (ii) conducting courses in mental health to equip health visitors more fully for their duties in this field.

By way of concentrating attention on this field, a detailed survey of families with multiple problems was begun at the end of the year.

(g) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

(i) Residential Nursery.

The Corporation has one residential nursery—Pitfodels House (which has accommodation for 82 children). The nursery is recognised for the training of nursery students.

The residential nursery is used for the children of parents who, for an adequate reason (such as mother in hospital), cannot look after their young children. Children taken into the care of the local authority and under two years of age are also accommodated.

(ii) Day Nurseries.

At present, the Corporation provide four day nurseries—Charlotte Street (with 60 places), View Terrace (44 places), Deeside (45 places), and Linksfild (30 places). All four have been recognised for training purposes.

The demand for vacancies continues to exceed the number of places available. The largest, Charlotte Street, continues to cause disquiet because of its unsuitability as premises for a day nursery.

7.—DOMICILIARY MIDWIFERY.

The only important change during the year was a decision by the Corporation that midwives should be permitted to use trilene, and the consequential training of all midwives in that form of anæsthesia. All the midwives were already qualified to administer gas and air anæsthesia.

The number of domiciliary confinements rose very slightly to 452. The attendance of a doctor at a domiciliary confinement continued to be a rarity: doctors were present at only 44 confinements in 1952, 31 in 1953, 29 in 1954, 21 in 1955, and 31 in 1956.

General.

At the end of 1956 the midwifery staff consisted of a Supervisor of Midwives (who also functions for the greater part of her time as Superintendent Health Visitor), an assistant, and eight whole-time midwives. A district of the City is

allocated to each midwife. In addition, the Corporation have an arrangement with the Board of Management for the Aberdeen Special Hospitals whereby a central district of the City is served by three midwives on the staff of the Aberdeen Maternity Hospital, and the Corporation pay £930 per annum towards the remuneration of these midwives. The small number of midwives is explained by the fact that the overwhelming majority of confinements in Aberdeen take place in hospital.

The Supervisor of Midwives is responsible for the supervision of all practising midwives in the City—not only those on the staff of the Corporation. At present, fifty-one midwives are employed in hospitals and nursing homes. During the year, 359 confinements were attended by municipal midwives and 91 confinements by midwives employed by the Board of Management for the Aberdeen Special Hospitals, a total of 450 (as compared with 444 in 1955, 476 in 1954, 471 in 1953, and 417 in 1952).

Births.

Particulars of the births, including still-births, which occurred in the City during 1956, are as follows:—

- (i) Total number of births occurring in the area during year, that is, before correction for mothers' residence:—Live births, 4,078; still-births, 116. Total 4,194
- (ii) Total number of above births occurring in institutions (including private maternity homes) 3,742
- (iii) Total number of above births occurring at home 452

These 452 may be further sub-divided thus to show attendance at birth:—

	Doctor engaged and present.	Doctor engaged but not present.	No doctor engaged.	Total.
Municipal midwives	23	332	4	359
Hospital midwives "on district"	8	67	16	91
Private practising midwives	—	—	—	—
No midwife	—	—	2	2
Total, 1956	31 (6·8%)	399 (88·4%)	22 (4·8%)	452
Comparable figures for 1955	21 (4·8%)	412 (92·8%)	11 (2·4%)	444
Comparable figures for 1954	29 (6·1%)	422 (88·1%)	28 (5·8%)	479
Comparable figures for 1953	31 (6·5%)	412 (86·7%)	32 (6·7%)	475

Administration of Analgesics.

(1) Gas and Air.

All the domiciliary midwives are qualified to administer gas and air analgesia; three sets of gas and air apparatus were in use at 31st December; and gas and air analgesia was administered by midwives in 375 cases during this year, while pethedine was administered in 225 cases. The comparable figures for 1955 were 377 and 215 respectively.

(2) Trilene.

During the year the Corporation decided to authorise the use of trilene by midwives, and all midwives received instruction in its administration, the training being given simultaneously with that offered to hospital midwives at the Maternity

Hospital. Three sets of trilene apparatus were on order at the end of the year but had not yet been delivered.

Use of cars.

One municipal midwife receives an allowance for the use of her own car. In emergency and at night, taxis are used by the other midwives.

Arrangements for ante-natal supervision by Midwives.

When a confinement is expected to take place at home, ante-natal supervision is given by the midwife concerned either in a duty room set aside for that purpose in the midwife's house or at the woman's own home. This supervision is given from the time of booking the midwife, and weekly visits are paid to the woman's own home during the last month. If any personal or environmental circumstances make it desirable that a confinement, originally booked as domiciliary, should in fact take place in hospital, the general practitioner and the midwife advise the woman accordingly. Wherever possible, however, arrangements for admission to hospital on social grounds or on grounds of anticipated obstetrical difficulty are made early in the pregnancy.

Refresher Course for Midwives.

Two midwives attended a refresher course at Inverness.

Training of Pupil Midwives.

The Aberdeen Maternity Hospital is, of course, a training hospital, and, as part of their training, midwives must obtain experience in domiciliary confinements under supervision. This is arranged through three midwives stationed at No. 32, Carden Place, and the Supervisor of Midwives gives lectures to the students before they begin their domiciliary work.

8.—HEALTH VISITING.

Some of the main features of the year were as follows:—

(1) There was a further spectacular increase in the total number of home visits paid by health visitors (from 108,418 in 1954 to 123,864 in 1955 and to 143,185 in 1956): this increase was not a result of additional staff, the number of health visitors employed during a considerable portion of the year being actually less than in 1955, but was due to saving of professional time by a vigorous policy of decentralisation.

(2) Both the number and the proportion of visits paid to expectant mothers continued to increase (from 7,335 visits in 1952 to 9,473 in 1955 and 11,412 in 1956)—an indication of the modern view that advice to expectant mothers, both about their own physical and mental health and social needs and about the physical and emotional requirements of children, constitutes a very important aspect of a health visitor's work.

(3) There was a dramatic increase in the number of old people receiving visits from health visitors. In 1953, the number of elderly citizens visited was 300; in 1954 it rose to 723, in 1955 it increased to 1,238, and in 1956 it advanced to 2,320.

(4) The grave shortage of health visitors continued during the year: special reports were considered by the Corporation in February and September, and a further special report was submitted shortly after the close of the year. At no time during the year were there fewer than 18 vacancies on the establishment. (The shortage is, of course, national, not simply local: a Government Working Party reported in June, 1956, that Britain should train at least 1,100 health visitors annually, whereas in 1951-56 the number of nurses who completed the post-qualification training were in the neighbourhood of 600 each year. Consequently the total shortage is probably of considerably greater degree than the shortage in any other profession.)

An extensive programme of health education, started in 1956, is considered in a separate chapter. Other features of the year included continuation of the use of health visitors in the training both of medical students (begun in 1952) and of student nurses (begun in 1954); continuation of the efforts (begun in 1954) to improve liaison between general practitioners and health visitors; and increasing attention by health visitors to mental and emotional health—including, for example, prevention of broken homes—following the intensive post-qualification courses in mental health organised in the department during the two previous years.

The Extension of the Work of Health Visitors.

The authoritative Report of the Working Party on the field of work, training, and recruitment of health visitors (a Working Party chaired by a very distinguished Aberdeen graduate, Sir Wilson Jameson, former Chief Medical Officer of the Ministry of Health) has defined the health visitor's primary functions as "health education and social service"; has stressed that health visitors should maintain contact with all families containing children; has emphasised the importance of mental health work; has indicated that, since the health visitor is a highly qualified professional officer, her time should not be wasted on unskilled or semi-skilled tasks; has pointed out that the health visitor has an important part to play in maintaining the health and well-being of the elderly; and has stated that the health visitor is "truly a medico-social worker—playing a full part in both preventive medicine and social action" and that she should therefore be responsible to an experienced member of her own profession (*i.e.*, a Superintendent Health Visitor) who should in turn be directly responsible to the Medical Officer of Health. The report has also suggested that the health visitor of the future needs both suitable personality and good educational background, has made recommendations for the further improvement of her professional training, has drawn attention to the dangerous shortage of qualified health visitor tutors (at present, even if sufficient suitable recruits appeared, there would not be anything like enough tutors to under-

take their training), and has strongly recommended that an immediate review should be made of health visitors' salaries.

In view of this authoritative report it may be useful to devote a page or so to outlining the vast expansion that the health visitor's rôle has undergone as a result of the National Health Service (Scotland) Act, 1947. Section 24 of the Act placed on local authorities a duty to make provision for the visiting of persons in their homes by health visitors to advise on the care, not only of expectant and nursing mothers and young children, but also of persons suffering from illness and on the measures necessary to promote health and to prevent the spread of infection. The duties of health visitors are, therefore, now statutory and are very much wider than they were before 1948. Instead of being concerned simply with the care of children and the prevention of infectious disease, the health visitor has become a recognised health adviser of the whole family, concerned with general promotion of physical and mental fitness, prevention of disease, and advising on the care and after-care of the sick. She is the person to whom a housewife can turn for advice on family budgeting, household economics, dietetics, personal hygiene, and matters relating to the physical and emotional health of all members of the family. Two factors, however, have made it impossible as yet for health visitors to cope fully with all the new duties; first, the fact that (as mentioned above) there is an alarming national shortage of these highly-trained officers; and second, the fact that the health visitor trained before 1948, although highly skilled in matters relating to the physical health of children, usually had inadequate knowledge of the mental and emotional development of children and virtually no training about the health of adults. In Aberdeen, the second point has in large measure been met by the provision of post-qualification courses in mental health, but the shortage of health visitors continues to make it impossible for all their duties to be undertaken. Nevertheless, in addition to continuation and extension of the older functions in relation to the care of young children and expectant and nursing mothers, many additional tasks are already being undertaken in Aberdeen. A few points may be selected for mention here. Where a premature baby is returned from the Maternity Hospital to its home, the appropriate health visitor immediately calls and, if deemed necessary, daily visits are paid to give advice to the mother with a view to ensuring that everything possible is done to enable the baby to become a healthy child. Again, health visitors devote much time and energy to encouraging mothers to have their children vaccinated against smallpox and immunised against diphtheria and whooping cough. Then again, the health visitors give talks to the mothers on health and social problems at six clinics; and, in addition, small groups of mothers who are expecting their first baby are given special talks and demonstrations at six centres in the City. These talks are deliberately given at the Child Welfare Clinics to encourage mothers to bring their babies afterwards to these clinics.

It is at last becoming appreciated that the prevention of disease of mental and emotional origin is one of the most important facets of a health visitor's work.

Indeed, the Secretary of State for Scotland has, himself, drawn attention to the rôle of the health visitor in the prevention of mental ill-health.

Already there are over 20,000 people of pensionable age in the City, and the health care of the elderly is a field which, in magnitude, will probably ultimately be as large as that of child welfare. Although the number of health visitors is not yet anything like adequate, during the year a considerable development took place in respect of the visitation of old people, the health visitors having been previously "geared up" for this work by a Study Week-end on the elderly at the end of 1954. During the year, regular visits were paid to some 2,320 elderly persons, as compared with 1,238 during 1955, 723 during 1954, and 300 during 1953. Schemes were also continued during the year for improved services for cripples and physically handicapped persons.

Health Visitors as General Purpose Social Workers.

The Working Party Report has termed the health visitor "a general purpose family visitor." In Aberdeen, to enable the health visitor to get to know her families more closely, and to avoid having too many social workers visiting the same homes, the health visitor already attends the school in her area as school nurse, and visits school children at home where necessary, as well as expectant mothers and pre-school children; she also visits elderly people in her area; and to a large extent she acts also as a social welfare visitor. It is intended that, ultimately, health visitors should also be responsible for the health and social welfare of cripples and handicapped persons in their area, although at present—while schemes are still in process of development—a specialist health visitor and a social worker are engaged on the visiting of physically handicapped persons.

Decentralisation.

To reduce the time spent in travelling, the old policy of having almost all the health visitors working from the main office has been abandoned. While some are still centred on Willowbank House, groups of health visitors have various clinics as their headquarters. This policy, which will be extended as new clinics are built, has already begun to bear fruits in a very substantial increase in the number of domiciliary visits paid.

Visitation by Health Visitors.

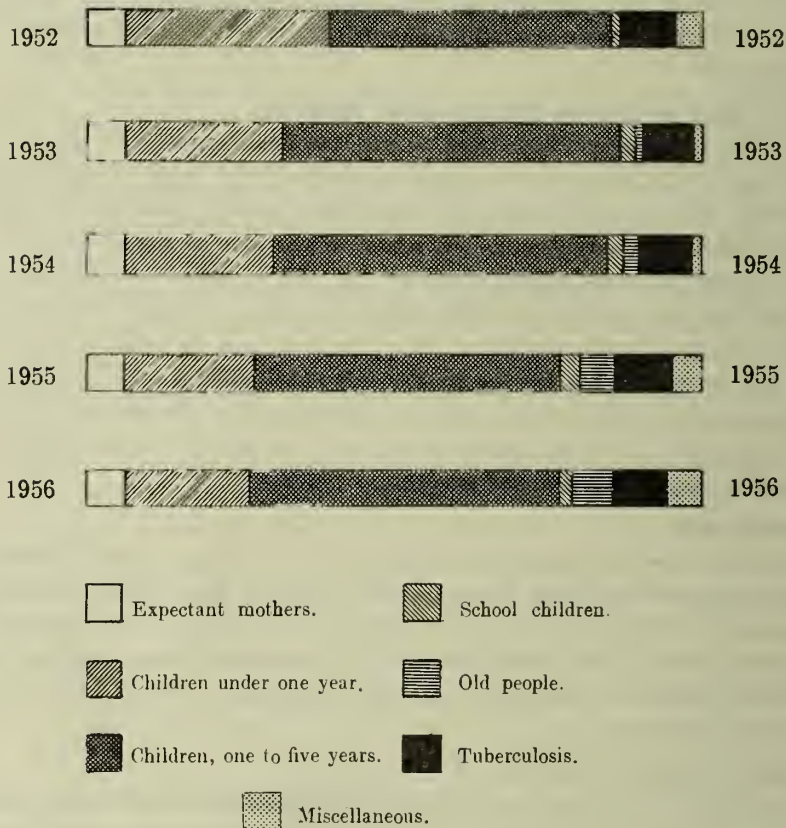
An analysis of the number of home visits made by health visitors during the year is given below, the total visits for 1955 and 1954 being also stated for purposes of comparison:—

	No. visited in 1956.	Total visits		
		1956.	1955.	1954.
(a) Maternity and Child Welfare—				
Expectant mothers . . .	2,629	11,412	9,473	8,745
Children under 1 year . . .	3,112	26,283	24,144	24,889
Children aged 1-5 years . . .	13,898	73,098	62,858	59,291
(b) Cases of tuberculosis . . .	1,645	11,172	11,799	10,882
(c) Other cases	10,890	17,916	13,239	4,611

In all, 143,185 home visits were paid, as compared with 123,864 in the previous year. It must, of course, be appreciated that, in addition to home visits, a good deal of work of the health visitors is carried out at Child Welfare Centres throughout the City. In point of fact, nearly 30 per cent. of their time is spent in clinic work and about another 20 per cent. in schools (including home visiting of school children, a feature which increased considerably in the latter part of 1956).

The diagram depicts the changes in visiting over recent years..

VISITING BY HEALTH VISITORS.



Liaison with Hospitals.

Liaison is very close in the case of some hospitals, *e.g.*, the Maternity Hospital (from which intimation of discharge of patients is always passed to the department and full particulars made available), the infectious diseases hospital, and the tuberculosis hospitals (in respect of which six health visitors and an assistant nurse undertake work which might otherwise be done by hospital almoners). In addition,

the Health and Welfare Department is notified about all babies discharged from the Mother and Baby Unit of the Aberdeen Royal Hospital for Sick Children, and also about children who are seen at the eye department; and all the local hospitals are at present intimating cases of home accidents and cases of pneumonia. The liaison is, therefore, in general, good, but attempts are constantly made to extend and increase it.

The discharge of an old person from hospital is not yet notified to the department (except that the almoner contacts the Nursing Superintendent where nursing equipment is required). It is, of course, unfortunate that elderly patients (who so often require such domiciliary services as health visitor's advice on health and social problems, chiropody, the mobile meals service, &c.) should be discharged from hospital without any intimation to the local authority, which may thus be deprived of any opportunity to carry out its statutory tasks of care and after-care. The main barrier is, of course, that—partly as a result of the sweeping advances in preventive and social medicine in recent years—members of the staffs of hospitals are often unaware of many of the functions and duties of local health authority officers. The development mentioned in the next paragraph should in time help to remove that unawareness.

A development of profound importance followed the decision of the General Nursing Council to include preventive and social aspects of disease in the general nursing curriculum. Starting in the autumn of 1954, student nurses at the combined training school of Aberdeen Royal Infirmary and Woodend Hospital now receive, in their final year, a short course of lectures given by members of the staff of the Health and Welfare Department, and these lectures are followed by visits by each student to private houses, clinics, &c., under the supervision of a health visitor. A similar but shorter course is provided for fever nursing students at the City Hospital. While these theoretical and practical courses can naturally teach the student nurses only the rudiments of disease-prevention and health promotion, they are nevertheless of supreme importance for the future improvement of liaison and co-operation. No two parties can co-operate without some idea of each other's aims and methods of work. Hitherto, the departmental medical officer and the health visitor have understood the aims and methods of their hospital colleagues by reason of the fact that they themselves worked in hospital before specialising in public health; and (as mentioned in the next paragraph) the use of health visitors in the practical training of medical students should ensure that the doctor of the future—whether in hospital or in general practice—knows a little about the preventive service. The new scheme—which, after two years, can now be regarded as established—should complete the circle by enabling the hospital nursing administrators and ward sisters of the future to understand something of the aims and methods of their colleagues in the preventive field.

Liaison with General Practitioners.

Although all degrees of co-operation and lack of co-operation are found, it can be said with confidence that the amount of liaison between general practitioners

and health visitors is slowly but steadily increasing. It is, of course, of the highest importance for the health and well-being of the community that every effort should be made to improve the co-operation of the two professional workers in closest touch with the family, the family doctor and the family health visitor; although it must be appreciated that, since the health visitor deals mainly with persons who are well while the general practitioner is concerned mainly with those who are sick, the opportunities for co-operation are less numerous than is sometimes suggested: the busy health visitor cannot devote more than a small fraction of her time to the sick, and the equally busy general practitioner may have little time to spare for those who are not yet ill.

In connection with liaison, three points which were mentioned in the report for 1955 may be briefly repeated:—

(a) In each of the last five years, health visitors have been used in the practical training of medical students. Each undergraduate spends the mornings of two weeks in visiting families in their own homes under the direction of a health visitor. Probably no measure yet devised has done more to improve co-operation in the future than this employment of the one professional officer in the training of the other.

Inevitably, this development consumes some of the time of the busy health visitor (and it has to be remembered that other encroachments on her time are in connection with the training of student health visitors and in connection with home visits now paid by student nurses), but it will undoubtedly pay rich dividends in the future.

(b) Two years ago an attempt was made to convince all health visitors that communication between themselves and general practitioners should as a rule be direct, not through the medium of the medical officer of health or the superintendent health visitor. A memorandum stressing the desirability of direct two-way contact was issued to all health visitors, and the theme was developed by the Medical Officer of Health at a meeting of health visitors. Particular emphasis was laid on these points—that the health visitor could often provide the general practitioner with information of considerable importance, that the general practitioner could frequently give the health visitor information of considerable importance, and that either party could take the initiative in contacting the other.

(c) After at least some health visitors had taken the initiative in endeavouring to develop better liaison with general practitioners, quite a number of practitioners evinced a desire for co-operation and for more knowledge of the special training and duties of health visitors. Through their representatives on the Standing Joint Medical Committee (a committee set up in Aberdeen in 1954 and containing three representatives each from hospital doctors, general practitioners, and public health medical officers), the family doctors asked that, to facilitate co-operation, they be given an indication of the health visitor's professional qualifications and functions. In response, a detailed memorandum was prepared by the Medical Officer of Health, in consultation with appropriate health visitors, and circulated to all general practitioners in the City. (The memorandum was printed in full in the Report for 1955).

9.—TRAINING OF HEALTH VISITORS.

Some of the main features of the year were—

- (1) Following the transfer of the health visitor training school to more satisfactory premises in 1955, some modernisation of the furniture and equipment was attempted in 1955-56.
- (2) The Corporation decided to extend the course of full-time training for student health visitors from seven months to one academic year, thereby bringing the course into line with parallel courses in England and Wales; since the student health visitor of the future will also have received certain instruction in the rudiments of public health, psychology and sociology in her general nursing training, the health visitor should in the years to come be better equipped than in the past for her many duties.
- (3) An additional prize was made available during the year, so that the training school now has four prizes—for all-round distinction, health teaching, family case-work, and public speaking, respectively.
- (4) While the unique success of 1955 (six of the first seven places in the national examination for the health visitor's certificate) was not repeated, for the fourth year in succession every candidate from the training school passed the national examination at the first attempt.
- (5) The question of increasing the maintenance grants payable to students was under consideration by the Corporation throughout the year, but no decision was taken during 1956.
- (6) As in previous years a study week-end was organised for trained health visitors, but the extreme shortage of health visitors made it impossible for a refresher course to be held in 1956.
- (7) During the year the Assistant Health Visitor Tutor obtained a scholarship for study abroad, adding a further item to the considerable list of distinctions gained in recent years by the staff of the training school.

Origin and Growth of the Training School.

Before 1948 there were in Scotland only two training schools in which selected state-registered nurses with the necessary midwifery qualification could take the additional full-time course to enable them to sit the national examination for the health visitor's certificate. One of these was in Glasgow under the auspices of the Corporation of that City, and the other in Edinburgh originally under the ægis of the University and later under the Health Committee of the Corporation. The vast extension of the duties of health visitors under the National Health Service Act,

1947, made it obvious that two training schools would no longer be adequate to meet the needs of the country. The Corporation of the third largest city in Scotland therefore decided to establish a training school.

The necessary central approval having been obtained, and various University departments having agreed to make available the services of members of their staff for instruction in special subjects, premises were equipped on the basement floor of 6, Castle Terrace, and a qualified health visitor tutor was engaged to take charge of the school and to supervise the theoretical and practical training of the students. Initially, there were considerably less than forty part-time lecturers (although the number rapidly increased)—professors and lecturers from the University, consultants employed by the Regional Hospital Board, senior members of the staff of the Health and Welfare Department, and other suitable persons with specialised knowledge.

During its early years the Training School was grossly hampered by complete inadequacy of accommodation, by unsuitable furniture, by lack of proper library, and by insufficiency of modern teaching equipment; and it also suffered from being a single-tutor school. Nevertheless, it did excellent work under the direction of Miss Milne (till 1952) and Miss Lamont (from 1952).

In 1953 the Corporation became aware that—despite the excellent results obtained—a one-tutor school was really an anachronism and that, if post-qualification training of trained health visitors was also to be undertaken, the appointment of a second tutor was imperative. Accordingly, in 1954 a second qualified health visitor tutor was engaged, so that the staff now consisted of a principal tutor, an assistant tutor, and over fifty part-time lecturers. In 1954 a fifty-hour post-qualification course in mental health was provided for twenty of the fifty health visitors who volunteered to take it, the course being held on Tuesday evenings and Saturday mornings, and the tutors acting as co-ordinators of the course and discussion leaders. In 1954 also, study days and study week-ends for health visitors on individual subjects were introduced.

In 1955 the school was transferred from the basement of 6, Castle Terrace, to the first and second floors of the same building. The accommodation now available includes two lecture rooms (with accommodation for 26 students), students' study, an adequate office for each tutor, a clerk's room, a small kitchen, &c. The building is old and the accommodation is by no means ideal, but it is a vast improvement on the dingy, overcrowded basement flat, and should do well enough for a few years until better accommodation can be provided.

A start towards the supplying of better equipment and more suitable furniture had been made in 1953 and 1954, and in 1955 and 1956 the furniture and equipment were brought up to a reasonable standard of adequacy.

In 1956 the Corporation decided to bring the training into line with that of most training schools in England and Wales by extending the course from seven months to one academic year.

Introduction of Prizes.

The Aberdeen Health Visitor Training School must, until 1955, have been one of the few educational institutions—if not the only one—training students for a profession but not encouraging the more able students by the provision of any prizes. In 1955 the Corporation decided to award each year a prize, to be known as the Corporation of Aberdeen prize, to the best all-round student; the two tutors offered to donate, during each year that they continued in their present posts, a prize for health teaching; and the medical officer of health offered to donate, during each year of his tenure of office, a prize for social case work.

The first prize-giving ceremony was held in April at Balnagask House (the premises then occupied by the School being too small), the prizes were presented by Dr. May D. Baird, and the prize-winners were—

Corporation of Aberdeen Prize . . .	Miss Alice Hay, R.G.N., S.C.M., R.F.N.
<i>Proxime accessit</i>	Mrs. Elizabeth J. Forsyth, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss M. M'Hattie, R.G.N., S.C.M., Q.N.
Tutors' Prize for Health Teaching .	Miss C. E. Greig, R.G.N., S.C.M.

At the second prize-giving ceremony, in April, 1956, the prizes were presented by Rev. Professor J. M. Graham, C.B.E., and the prize-winners were:—

Corporation of Aberdeen Prize . . .	Miss Rachel Simpson, R.G.N., Part I C.M.B.
<i>Proxime accessit</i>	Miss Sheila E. Paterson, R.G.N., S.C.M.
Medical Officer's Prize for Case Work	Miss Malina Campbell, R.G.N., S.C.M., S.R.C.N., Q.N.
Tutors' Prize for Health Teaching .	Miss Muriel Tocher, R.G.N., S.C.M., Q.N.

An Additional Prize.

During 1956 the Western Division of the Scottish Health Visitors' Association generously offered each of the three training schools in Scotland an annual prize for public speaking, the prize to be known as the Violet Robertson Prize, in memory of the late Baillie Violet Robertson, a former President of the Scottish Health Visitors' Association.

The School's Results.

The success of the School can be judged by its results. In four consecutive years, 1953, 1954, 1955, and 1956, not a single student from the School failed to pass the national examination at the first attempt. In 1953 and 1954, a student from the School took first place each year in the national examination, and in 1955 a student from the School and a Glasgow student tied for first place. In 1955 also, Aberdeen students took the next five places in the examination, thus securing six out of the top seven places.

In respect of selection of students, a health visitor course (like any other post-qualification course) has a considerable advantage over courses which take their entrants straight from school; since the intending students are already mature adults with two previous professional qualifications, there would clearly be something wrong with the selection of candidates if the failure rate were as high as, say in the case of medical or arts students, or student nurses, or apprentice sanitary inspectors. Nevertheless, the Report of the Working Party on Health Visiting indicates that, in five consecutive years, the proportion of student health visitors failing to pass the national examination at the first attempt was 14, 12, 13, 15, and 12 per cent. respectively. It is therefore gratifying in the extreme that, in the last four years, Aberdeen has trained exactly 80 health visitors without a single failure in the examination.

In the report for 1955 mention was made of various distinctions gained by members of staff and by a recent ex-student (including the holding, during 1955, by Miss D. J. Lamont, Principal Health Visitor Tutor, of the very high award of a World Health Organisation Senior Travelling Fellowship, and the securing by Miss M. Nairn of a British Commonwealth and Empire Travelling Scholarship). In 1956 Miss M. M. Byrne, Health Visitor Tutor, was awarded a National Association for Tuberculosis Travelling Scholarship to study tuberculosis services in the Netherlands, and just after the close of the year it was announced that Miss D. J. Lamont, Principal Health Visitor Tutor, had gained the first prize of the Royal Society of Health for an essay on "The advantages and disadvantages of amalgamation of Health Departments and Welfare Departments."

Number of Students trained.

Owing to the grave national shortage of suitable recruits to health visiting, there are vacant places in all the Training Schools. From the aspect of local reputation, it is at least satisfactory that, at the end of 1955, there were only five vacant places in the Aberdeen School (as contrasted with about eight and eighteen in Edinburgh and Glasgow, respectively). The number of students trained each year and the number subsequently employed by the Corporation were as follows:—

Year.	Total Number of Students.	Number later Employed by Corporation.
1948 . . .	20	6
1948-49 . . .	20	8
1949-50 . . .	19	7
1950-51 . . .	21	9
1951-52 . . .	19	7
1952-53 . . .	20	10
1953-54 . . .	17	4
1954-55 . . .	22	10
1955-56 . . .	21	10
1956-57 . . .	18	Still in training.

Visitors to Training School.

Visitors to the Training School in 1956 included public health experts from New Zealand, the United States, Australia, Eire, and Yugoslavia, in addition to a number from various areas in Britain.

In-Service Training of Health Visitors.

Health visitors trained before 1948, and even those trained in the years of transition, 1949-53, were given theoretical and practical instruction mainly in the old aspects of a health visitor's work—advising about the physical aspects of the health of children and expectant mothers, the prevention of infectious diseases, &c. They received very little, if any, training in the promotion of mental health, the prevention of diseases of mental and emotional origin, the maintenance of health in the elderly, and the application of the techniques of health education to non-infectious diseases. To equip these health visitors for their important new duties, post-qualification training is essential; and, since medico-social knowledge is in a phase of rapid increase, a whole series of post-qualification courses will be necessary.

In 1956 (as in previous years) a study week-end was held, the subjects reviewed being—(a) Changing scope of the health visitor's work—delegation, relegation, and promotion—introduced by Miss B. M. Langton, Superintendent Health Visitor, Salford; (b) The health visitor's rôle in social work—introduced by Miss I. Windmuller, specialist health visitor for social problems, Salford; and (c) Health education—introduced by Dr. I. A. G. MacQueen.

In 1954 and 1955 some 46 of the Corporation's health visitors attended intensive courses in mental health work. These courses were outstandingly successful and attracted much attention in medical and health visiting circles. In 1956, however, it was reluctantly decided that the existing shortage of health visitors and the consequent amount of additional work falling on the health visiting staff were such that it would be unwise to try to hold a refresher course during the year.

10.—HOME NURSING.

During the year there was a slight increase in the number of visits paid by the day nursing service, and a slight decrease in the numbers of patients requiring the night nursing service.

General.

Aberdeen is one of the twelve local health authorities that do not themselves employ district nurses. The Corporation discharge their duty to secure the attendance of nurses on persons who require nursing in their own homes through the agency of the Aberdeen District Nursing Association, the expense being met by the Corporation. The Lord Provost, the Treasurer, the Convener of the Health and Welfare Committee, and one other Councillor, together with the Medical Officer of Health, are members of the Committee of the District Nursing Association, and during the last three years the Superintendent Nursing Officer has been co-opted to the Committee.

Co-operation.

As might be expected, the majority of the cases dealt with by the nurses employed by the Nursing Association are referred to them by general practitioners, although quite a proportion are initially discovered by the health visitors and referred either through the Health and Welfare Department or via the appropriate general practitioner. Also, in cases where a patient is discharged from hospital and requires nursing attention, an almoner at the hospital may contact the Superintendent of the Nursing Association to arrange for a nurse to provide that attention.

There is a standing arrangement that each month a list of old people who are convalescent and no longer require nursing attention is furnished by the Nursing Association to the department, so that appropriate health visitors can pay periodic visits to the old people to give medico-social advice and to ensure that they are getting any necessary assistance, *e.g.*, home helps, meals on wheels, &c.

Nursing of Children.

In view of the decrease in diseases of children that has followed the expansion of the preventive services, and in view of the very adequate hospital facilities available, there would appear to be no need for special provision for the domiciliary nursing of sick children in Aberdeen. Where children require home nursing, each nurse is responsible for the nursing of children in her district.

Type of Nursing.

Over 60 per cent. of all visits are now paid to persons over the age of 65 years.

The day nursing service paid a total of 109,410 visits to 2,163 persons over 65 years and 2,413 persons under 65.

The night nursing service paid a total of 3,128 visits to 266 patients over 65 years and 71 persons under 65.

Classification and proportions of main types of cases.

The number of patients visited during the year was 4,913, as compared with 5,205 in 1955, 4,920 in 1954, 4,373 in 1953, and 4,115 in 1952; and the total visits numbered 112,538, as compared with 111,638 in 1955, 102,860 in 1954, 88,870 in 1953, and 82,788 in 1952.

The classification and proportions of the main types of cases dealt with by the nurses employed by the Nursing Association are as follows:—

Classification and Proportions of Main Types of Cases in 1956.

DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	- 65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal . . .	287	468	755	5,046	4,933	9,979	442	313	534	64	32	75
Accidents . . .	60	113	173	1,392	2,346	3,738	90	83	132	12	3	26
Amputations . . .	19	4	23	440	330	770	11	12	13	3	1	6
Anæmia . . .	25	149	174	499	3,137	3,636	68	106	54	9	15	96
Cancer . . .	89	116	205	2,409	3,835	6,244	95	110	26	19	122	38
Cardiac . . .	243	356	599	7,890	13,064	20,954	210	389	171	77	121	230
Cerebral Hæm. . .	111	178	289	4,410	6,044	10,454	48	241	52	44	113	80
Diabetes . . .	11	96	107	1,896	13,476	15,372	30	77	38	9	5	55
Gynæcological . . .	—	41	41	—	563	563	30	11	30	1	1	9
Miscellaneous . . .	323	785	1,108	4,125	9,226	13,351	841	267	917	78	33	80
Nervous . . .	28	69	97	1,161	2,553	3,714	61	36	47	11	8	31
Respiratory . . .	296	334	630	3,164	3,374	6,538	405	225	521	35	35	39
Rheumatism . . .	22	71	93	626	3,296	3,922	36	57	37	9	6	41
Senility . . .	57	130	187	1,496	3,843	5,339	7	180	42	32	58	55
Varicose Ulcers . . .	15	80	95	453	4,383	4,836	39	56	45	11	5	34
Total . . .	1,586	2,990	4,576	35,007	74,403	109,410	2,413	2,163	2,709	414	558	895

Staff.

The staff of the day nursing service totalled 34 full-time nurses at the end of the year (including the Superintendent and one assistant) and two part-time relief nurses. This also was the total for 1955. The night nursing staff are mentioned separately below.

Night Nursing Service.

The night nursing service (inaugurated early in 1952, and slightly extended and somewhat re-organised during 1953 in the light of the experience gained during the first year of operation) underwent little alteration during 1956. The service has already proved very useful. Its main function will probably ultimately be the provision of occasional skilled nursing (*e.g.*, visiting patients for four-hourly injections of penicillin or for injection of pain-killing drugs), but, so far, it has served mainly to provide nursing care for persons living alone or for persons whose relatives were exhausted from looking after the patient on previous nights. In 1956 the staff employed on night work amounted to three trained nurses and two assistant nurses on a full-time basis and four trained nurses on a part-time basis. In all, 337 cases were attended during the year, and 3,128 visits were made.

Details of the cases dealt with are given in the following table:—

NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	- 65	65+	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal . . .	5	1	6	27	19	46	3	3	3	1	2	—
Accidents . . .	1	6	7	1	29	30	1	6	3	1	3	—
Anæmia . . .	1	—	1	1	—	1	—	1	—	—	1	—
Cancer . . .	40	38	78	342	393	735	33	45	5	3	67	3
Cardiac . . .	20	47	67	198	321	519	10	57	17	9	38	3
Cerebral Hæm. . .	28	39	67	228	400	628	5	62	12	11	41	3
Diabetes . . .	—	1	1	—	2	2	—	1	1	—	—	—
Miscellaneous . . .	5	7	12	9	14	23	1	11	2	2	7	1
Nervous . . .	4	7	11	12	71	83	7	4	6	2	1	2
Respiratory . . .	13	18	31	69	203	272	6	25	7	9	13	2
Rheumatism . . .	1	6	7	1	104	105	5	2	3	1	2	1
Senility . . .	16	33	49	85	599	684	—	49	9	7	27	6
Total . . .	134	203	337	973	2,155	3,128	71	266	68	46	202	21

Training of District Nurses.

The Association undertakes training for the Queen's Certificate. At the end of the year, seven students were receiving training.

The Report of the Working Party on District Nurses—published just before the end of 1955—has recommended certain changes, including a reduction in the length of training of trained nurses taking the district nursing course.

11.—DOMESTIC HELP SERVICE.

Salient features of the year were—

- (1) a further sharp increase in the number of elderly persons assisted by home helps, such increase being a feature that had been anticipated;
- (2) an increase in the total number of households assisted; and
- (3) as an inevitable concomitant to (1) and (2), a rise in the number of domestic helps employed.

In the course of the year, the number of domestic helps employed was increased to the maximum figure authorised by the Corporation, namely, 120 full-time helps or an equivalent number of part-time helps. At the end of the year, as the demand for help continued to rise, application was made to the Corporation for a further increase in the establishment. The approval of the Secretary of State has been obtained for an ultimate extension of the number employed to 200.

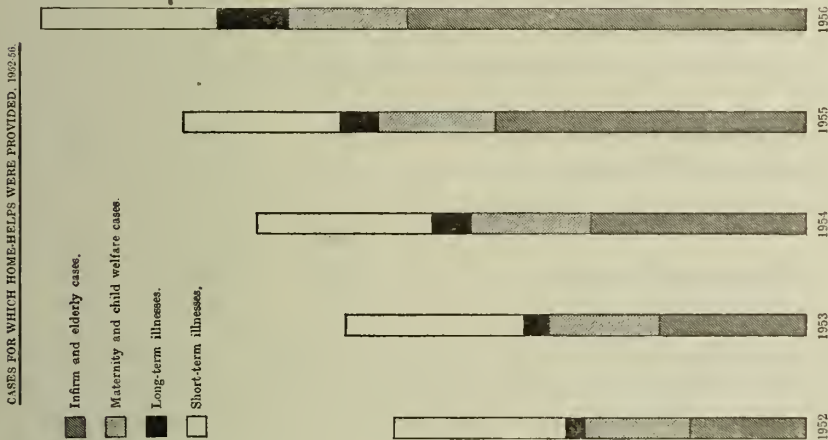
Households which may qualify for the domestic help service (whole-time or part-time) include those where there is a sick person, an expectant mother, a mentally defective person, an elderly person, and certain other categories. A charge is made for the home help, and is based on the applicant's income. In the lowest income group (persons on national assistance), the minimum charge is refunded by the National Assistance Board.

The following table shows the number of domestic helps in the service at December, 1956, as compared with the previous five years:—

	1956.	1955.	1954.	1953.	1952.	1951.
Whole-time	51	48	44	36	36	35
Part-time	148	132	97	52	39	27

The demand in Aberdeen is mainly for part-time service, especially in the mornings. The following statement shows the distribution of the cases attended during 1956, as compared with the previous four years, and the same information is given in diagrammatic form:—

	1956.	1955.	1954.	1953.	1952
Total number of cases for which helps were provided .	1,494	1,214	1,070	899	807
(a) Maternity and Child Welfare cases	235	226	236	208	207
(b) Infirm and elderly cases (over 65)	778	608	420	287	225
(c) Long-term illnesses (other than (b))	128	71	75	53	32
(d) Short-term illnesses (other than (a) or (b))	353	309	339	351	343



The question of a sitter-in service has not yet been considered by the Corporation.

12.—VACCINATION AND IMMUNISATION.

Some of the main features of the year may be summarised as follows:—

1. The proportion of babies receiving vaccination against smallpox rose slightly to 73 per cent., as compared with 70 per cent. in 1955, and 71 per cent. in 1954.
2. The proportion of pre-school children immunised against diphtheria continued to rise slowly but steadily—the figures for consecutive years being 51 per cent. in 1952, 56 in 1953, 59 in 1954, 62 in 1955, and 64 per cent. in 1956.
3. The number of school children receiving primary immunisation against diphtheria decreased (because the majority of school entrants had been immunised at an earlier age), but the number receiving reinforcing injections was greater than in any previous year.

4. The number of babies inoculated against whooping cough was higher than in any previous year.

5. During the year the Health and Welfare Department continued to hold a research grant from the Advisory Council for Medical Research to pay in full for the cost of an investigation of the efficacy of combined immunisation against diphtheria, whooping cough, and tetanus.

6. As in other areas, vaccination against poliomyelitis was—for the first time—made available to a limited extent.

7. In 1956, as in previous years, general practitioners undertook a smaller amount of vaccination, immunisation, and inoculation than did the local authority staff. For smallpox vaccination, the proportions for the last three years are—

	1956.	1955.	1954.
General practitioners	43%	43%	41%
Local authority staff	57%	57%	59%

For primary immunisation against diphtheria the proportions are—

	1956.	1955.	1954.
General practitioners	30%	33%	31%
Local authority staff	70%	67%	69%

For inoculation against whooping cough the proportions are—

	1956.	1955.	1954.
General practitioners	36%	39%	36%
Local authority staff	64%	61%	64%

For reinforcing injections against diphtheria the figure for 1956 was 96 per cent. by local authority staff and 4 per cent. by general practitioners. In the two previous years 95 per cent. of reinforcing injections were given by public health medical officers and 5 per cent. by general practitioners.

(1) VACCINATION AGAINST SMALLPOX.

There is possibly some validity in the statement that compulsion is an indication of national immaturity and that, as civilisation progresses, persuasion can frequently replace compulsion. Vaccination against smallpox is still as necessary as ever, or perhaps more necessary than ever in view of the increased possibilities of infection consequent on the spread of air travel, but, since 1948, compulsory vaccination has been abolished and reliance placed on the persuasive efforts of the local authority. In all clinics and also in the course of their visits to the infant's home, the health visitors impress upon each mother the necessity of having her baby vaccinated against smallpox. The actual vaccination is performed either by the child's general practitioner (who receives a standard fee for notifying vaccination to the local authority) or—more frequently—by local authority doctors at child welfare clinics.

The total number of primary vaccinations in 1956 was 2,738, as compared with 2,493 in 1955 and 2,640 in 1954. During 1956, 1,171 vaccinations were notified by general practitioners and 1,567 were done at local authority clinics. The comparable figures for 1955 were 1,076 by general practitioners and 1,417 at clinics. The following table gives an analysis of primary vaccinations by year of birth and type of reaction, the totals for 1955 being appended for purposes of comparison:—

ANALYSIS OF PRIMARY VACCINATIONS.

Year of Birth	Typical Vaccinia greatest at 7th-10th day	Accelerated (Vaccinoid) Reaction 5th-7th day	Greatest Reaction 2nd-3rd day	No Local Reaction	Total
1956	1,536	...	7	100	1,643
1955	783	4	10	84	881
1954	67	...	...	8	75
1953	28	1	1	2	32
1952	17	1	...	1	19
1951	14	...	1	...	15
1950	4	...	...	...	4
1949	7	...	...	...	7
1948	2	...	...	...	2
1947 . . . . .	...	...	...	...	...
1946	58	...	...	1	59
Totals	2,516	6	19	196	2,737
Totals for previous year .	2,349	9	11	124	2,493

In the era of compulsory vaccination, about 85 per cent. of children in Aberdeen were actually successfully vaccinated; the Registrar-General's report for 1947 gives the figure of 85·1 per cent. for children born during 1946. For children born in 1955, the proportion successfully vaccinated by the end of 1956 was 73 per cent., and from the table it would appear that this figure is likely to be maintained in the case of children born during 1956.

For propaganda purposes, reliance has in recent years been placed almost exclusively on the influence of the family health visitor.

(2) IMMUNISATION AGAINST DIPHTHERIA.

(a) Cases of Diphtheria.

No cases occurred in 1956: Aberdeen has now had in four consecutive years only two cases, both in persons who had never been immunised. There has been no fatal case of diphtheria in the City since 1950, in which year a non-immunised child died.

(b) Propaganda employed for Primary Immunisation.

As in the case of vaccination against smallpox, the health visitors during their home visiting make a strenuous effort to ensure as far as possible that all children are immunised against diphtheria in their first year of life. While leaflets and posters may have their uses, it is felt that the personal approach by the health visitor is the thing of supreme value, and that all other measures of propaganda are merely supplementary.

(c) Re-immunisation.

Efforts are made to ensure that as many children as possible receive a reinforcing dose either just before going to school for the first time or in their first year at school; and a second reinforcing dose is available about three years later.

(d) Numbers Immunised.

The numbers of individuals who completed a full course of immunisation or who received a reinforcing injection during 1956 are given in the accompanying tables. Figures for 1955, 1954, and 1953 are also provided for purposes of comparison.

DIPHTHERIA IMMUNISATION.

	Primary Immunisation				Reinforcing Dose			
	1956	1955	1954	1953	1956	1955	1954	1953
Number Immunised—								
(a) By General Practitioners	969	1,074	1,031	1,105	194	223	200	186
(b) At Child Welfare Clinics	1,719	1,573	1,639	1,721	242	201	166	230
(c) By School Health Service	577	613	630	970	4,617	4,205	3,614	3,768
	3,265	3,260	3,300	3,796	5,053	4,629	3,980	4,184

In other words, 30 per cent. of primary inoculations were carried out by general practitioners and 52 per cent. by doctors at child welfare clinics. Eighteen per cent. of primary inoculations were undertaken at school (about four years late), and the school health service also carried out over 90 per cent. of the reinforcing injections.

A more detailed breakdown of the immunisations performed during 1956 is given in the table on the next page.

DIPHTHERIA IMMUNISATION.

The following tabulated statement shows the number of children immunised each year since 1947:—

Age in years on 31st December of the corresponding year.	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	Total Immunised at 31st December, 1956.
Under 1 Year	102	119	88	103	140	169	334	438	550	700	Aged under 5 Years 9,723
1 Year	972	1,171	1,270	1,345	1,506	1,511	1,686	1,688	1,696	1,594	
2 Years	427	268	426	671	418	351	398	253	188	239	
3 "	170	87	138	216	116	115	193	128	76	69	
4 "	118	64	50	106	79	72	130	85	63	43	
5 "	286	220	196	230	236	281	266	206	153	152	
6 "	498	382	428	438	427	563	575	355	340	305	Aged 5 Years and over 22,425
7 "	47	32	25	32	16	16	27	17	6	11	
8 "	40	22	9	15	13	6	10	6	7	8	
9 "	393	350	236	142	209	171	164	119	169	127	
10 "	28	7	4	3	4	3	4	1	4	4	
11 "	17	9	2	4	3	2	3	...	1	7	
12 "	14	16	3	3	9	2	3	1	...	4	Grand Total—1947-1956 32,148
13 "	9	1	1	...	2	...	...	1	...	1
14 "	4	2	1	...	...	...	1	...	1	...
15 Years and over	5	9	3	3	2	5	2	2	6	1	
Total each Year Immunisations	3,130	2,759	2,880	3,311	3,180	3,267	3,796	3,300	3,260	3,265	
Reinforcing Injections	2,785	2,998	2,855	3,189	3,210	3,941	4,184	3,980	4,629	5,053	

(e) Percentage of Pre-school children who were immunised against Diphtheria at end of 1956.

For five years the percentage of children aged 0-5 years recorded as being protected against diphtheria has risen steadily—from 51 in 1952 to 56 in 1953, 59 in 1954, 62 in 1955, and now 64 in 1956. While the trend is definitely in the right direction, it is highly desirable that the figure be raised still further. It must be emphasised that immunisation is a valuable safeguard against a dangerous disease, and that the Aberdeen figures still compare poorly with those of a number of other areas.

(f) Percentage of School children immunised against Diphtheria.

As mentioned in the section of this report dealing with school health services, 92·4 per cent. of school children in Aberdeen have been immunised at some time.

(3) IMMUNISATION AGAINST WHOOPING COUGH.

Although the Department of Health for Scotland has not yet given official approval to any vaccine as being completely efficacious, the Corporation—which carried out diphtheria immunisation some sixteen years before that form of protection was officially accredited—undertakes immunisation against whooping cough at the child welfare clinics. The health visitors encourage all mothers to have their children immunised either at the clinics or by their own general medical practitioners.

The following table gives the numbers immunised against whooping cough during 1954, 1955, and 1956:—

	1954.	1955.	1956.
By general practitioners	903	1,016	978
At clinics	1,580	1,563	1,733
	<hr/>	<hr/>	<hr/>
Total	2,483	2,579	2,711
	<hr/>	<hr/>	<hr/>

(4) RESEARCH PROJECT—COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS.

Although tetanus is a relatively rare disease, it has a very high mortality rate when it occurs. There are in Britain about 80 deaths each year from this cause, and there would undoubtedly be many more cases were it not for the universal hospital practice of giving injections of anti-tetanic serum to every patient with an open injury. This serum quite frequently gives rise to very unpleasant, though not serious, reactions. For these reasons, if some other means of preventing tetanus can be used, it is desirable that it should be introduced into the normal programme of immunisation of children. As a result of war-time and other experience, it has been proved that there is an efficient agent. Unfortunately, to immunise children separately for tetanus would increase the number of injections necessary. Nobody would willingly contemplate the prospect of young children receiving eight separate

injections in their first year—one for smallpox, three for whooping cough, and two each for diphtheria and tetanus; and, in the unlikely event of parents acquiescing in such an inordinate number of injections, the child might well come to associate the clinic with pricks from a needle.

As a result of work in France and elsewhere, it is known that protection against diphtheria and tetanus can be given by injecting a mixture of the two antigens without decreasing the potency of either, and has also been shown in this country and in the United States that diphtheria and whooping cough antigens can similarly be used together. A preparation of all three has proved effective in the laboratory and, to assess clinical efficiency, the Advisory Council for Medical Research has made available funds for a survey which is being carried out in Edinburgh and Aberdeen. The research grant pays in Aberdeen for the half-time services of a research medical officer, the full-time services of a research health visitor, and the half-time services of a clerk.

The object of the survey was to compare the effectiveness of immunisation against whooping cough in two groups of children who differed only in the method by which they were immunised against whooping cough. One group received three injections of a combined whooping cough, diphtheria, and tetanus prophylactic; the other group received three injections of a whooping cough prophylactic, followed by two injections of a diphtheria tetanus prophylactic, making five injections in all. These injections were given by arrangement with, and by the consent of the parents, who responded very well to the invitation to take part.

The actual immunisation part of the programme was completed during 1955; each child taking part in the survey will be visited monthly for two years from the date of the immunisation, with the intention of identifying and recording the occurrence of cases of whooping cough, and of contact with whooping cough. In addition, each parent has been provided with a card and envelope to be used for notifying the Medical Officer of Health of a case of whooping cough in an immunised child, or of a suspicious cough which may be a sign of an early or a mild case of whooping cough. At the end of the survey the information from Edinburgh and Aberdeen will be put together and analysed statistically to identify differences between the two groups.

(5) COMBINED IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH, AND TETANUS—ROUTINE PROCEDURE.

The research investigation mentioned above concerns certain children immunised in 1954 and 1955. The results will not be fully known until 1958.

In 1956 the question arose as to whether combined or separate immunisation should be employed pending the conclusion of the investigation. Some points to be considered were—

- (a) the proved safety of combined immunisation and the absence of unpleasant reactions;

- (b) the inevitable decrease in immunisation that would follow reversion to single immunisation procedures;
- (c) the likelihood that children who received eight separate injections would associate the clinic with injections; and
- (d) the adoption of combined immunisation against the three diseases as a routine procedure in certain areas in Canada and the United States.

During most of 1956—while these matters were being considered—children were offered only protection against diphtheria and whooping cough, but a decision was taken to reinstitute combined immunisation against the three diseases as from 1st January, 1957.

(6) VACCINATION AGAINST POLIOMYELITIS.

During the year the Department of Health for Scotland made poliomyelitis vaccine available for children aged 2-9 years, but supplies were very short throughout the year. The actual number of children protected during 1956 was 426.

(7) IMMUNISATION AGAINST TUBERCULOSIS.

(a) Immunisation of Contacts.

Immunisation of contacts is carried out under the direction of the Chest Physician at the City Hospital, although a small amount of skin testing is carried out at child welfare clinics.

(b) Immunisation of School Children.

In 1953 the Corporation decided to carry out tuberculin testing and B.C.G. immunisation of school leavers and particulars of the work done were recorded in the "School Health Service" section of the report for that year. The Department of Health for Scotland in 1954 recommended to all local authorities that they should make provision for similar services in their areas.

During 1955 and 1956 B.C.G. immunisation was offered to all children aged 13 years and upwards. A summary is given in the section of this report dealing with Prevention of Illness, Care, and After-Care.

(8) OTHER IMMUNISATIONS.

Persons going abroad to certain countries need to be immunised against such diseases as yellow fever, &c., and in Aberdeen this immunisation is normally carried out at the City Hospital.

13.—PREVENTION OF ILLNESS, CARE, AND AFTER-CARE.

A very large scale development at the close of 1956 was the introduction of the health guidance project, discussed in a separate chapter. If, however, this feature is temporarily ignored, 1956 can be viewed as a year of attempted consolidation and of constant struggle against staff shortages and lack of accommodation. It is perhaps useful to look at the years 1953-56 as presenting a pattern: 1953 was the year of foundation laying (*e.g.*, the alteration of the Corporation's scheme to permit of future developments, and the decision to undertake B.C.G. immunisation in advance of the Government's general authorisation); 1954 was the year of building (*e.g.*, the extension of the chiropody service, the development of a register of elderly persons, the provision of health services for elderly persons, the first home safety campaign conducted by a local authority, the setting up of a register of handicapped persons, and the starting of services designed to help such persons); 1955 was a year in which the new services quietly developed (*e.g.*, there was a vast increase in the number of elderly citizens being visited by health visitors and an extension of the chiropody service); and, in 1956, despite the shortages already mentioned, there were some further extensions (*eg.*, in the health maintenance of the elderly) but, on the whole, the dominant feature of the year was consolidation—to such extent as the shortage permitted.

(A) TUBERCULOSIS.

(a) General Outline.

While it is the duty of the Regional Hospital Board to provide institutional care and appropriate medical and nursing services, all the functions relating to prevention, care, and after-care are entrusted by statute to the local health authority. Some of these functions may be thus summarised:—

(i) *Contact tracing and follow-up.*—A patient may be notified by a general practitioner or (more usually) by a chest consultant to whom the patient has been referred by the practitioner. Immediately a case is notified, the health visitor for the particular area visits the home and ascertains the persons in the house, sleeping accommodation, family medical history, names and addresses of frequent visitors, &c.; and endeavours are made to have all members of the household and other close contacts radiologically examined at the City Hospital. This intensive follow-up of all cases is of greatest value and may be the means of other members of the household keeping clear of the disease. It is also of profound epidemiological importance;

tuberculosis is spread principally by unsuspected, undiagnosed persons. Hence the stress on frequent visitors and other close contacts.

(ii) *Co-operating with the Regional Hospital Board and with general practitioners* in determining the need of patients for admission to hospital. The Senior Chest Physician acts in respect of preventive work as an honorary member of the staff of the department, with six health visitors seconded to him. He therefore has at his disposal his own clinical record, a comprehensive report submitted by the health visitor on home and social circumstances, and any information made available to him by general practitioners. He is thus in a very strong position to make a sound decision about the relative needs of different patients for admission.

(iii) *Assisting households with a tuberculous member to obtain adequate accommodation.* The Corporation, some years ago, adopted a policy whereby tenancy of Council houses is, in appropriate cases, granted to persons suffering from "open" tuberculosis, to allow segregation of the infectious case. It should, however, be appreciated that, with over 200 cases of tuberculosis notified annually, it is not practicable to allot houses to all tuberculous patients.

(iv) *Advice by health visitors to persons suffering from tuberculosis and living at home.* This advice covers the proper segregation of the patient from the rest of the household and the precautions which should be taken with a view to improving environmental hygiene, maintaining general health, increasing resistance, and generally ensuring that the remainder of the household do not contract tuberculosis. It also includes advice about financial allowances available and sources of help.

(v) *Arranging, where necessary, for boarding-out of child contacts.* Under the Corporation's Proposals for the Discharge of Functions, arrangements are made whereby child contacts can be sent to Linn Moor Home, Culter, a convalescent home run by a voluntary organisation. The Corporation, of course, make a payment in respect of the boarding-out of such child contacts. The period of residence in Linn Moor Home varies according to the health of the child.

(vi) *Providing beds, bedding, and nursing requisites.* In certain circumstances a loan is given of beds and bedding on the recommendation of the Chest Physician after the health visitor has submitted a report on the home conditions.

(vii) *Co-operating with Ministry of Labour* in resettlement of tuberculous persons in employment or in their entry to sheltered employment. With regard to the resettlement of tuberculous persons, the Chest Physician is in close contact with the Ministry of Labour and National Service to ensure that patients who have suffered from tuberculosis obtain employment suitable to their condition. The Corporation also send patients to Papworth Village Settlement and to the British Legion Village at Preston Hall, where tuberculous patients unfit for their previous

occupation may obtain training in other occupations. At the end of the year there were two persons resident in Papworth Village Settlement for whom the Corporation were making a contribution towards maintenance.

(viii) *Co-operation with the voluntary after-care committee for tuberculosis.* This Committee is mentioned on page 95. Co-operation is assured, since the Honorary Secretary, one of the three Vice-Presidents, and several members of the committee are members of the staff of the Health and Welfare Department.

(b) Co-ordination with diagnostic and curative service.

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. When discharging functions under these arrangements, the physician is regarded as having the status and responsibilities of a Deputy Medical Officer of Health (Tuberculosis); and—as indicated above—a number of health visitors are employed full-time on tuberculosis work and operate under the direction of the Chest Physician.

Co-ordination is facilitated by the fact that the Chest Physician has himself had considerable experience of local authority work and by the fact that the tuberculosis health visitors undertake the duties which in some other areas are discharged by almoners. In practice, co-ordination is extremely good. When a case of tuberculosis is notified to the Medical Officer of Health by a general practitioner, the notification is forthwith intimated to the Chest Physician and, where a suspected case is referred by the practitioner to the Chest Physician, the notification is made by that officer whenever diagnosis is complete. Moreover, where deemed desirable, action can be taken in advance of any formal notification. A sanitary inspector's report and a health visitor's report are made available so that the Chest Physician has full information on clinical state, family circumstances, housing conditions, &c. In the light of the full information, the Chest Physician is enabled to reach decisions about the patient's admission to hospital. Contacts, as already mentioned, are followed up by local authority health visitors and urged to attend for examination by the Chest Physician, and health visitors advise patients about hygienic aspects when living at home, about allowances, and help available. When discharge of a patient from hospital is contemplated, the Medical Officer of Health is notified of any particular needs. Indeed, the complete co-ordination and co-operation that exists in respect of tuberculosis might well serve as a model for the setting up of schemes for other diseases.

(c) Examination of contacts.

The patient's family or household are regarded as a unit and, as already stated, an endeavour is made to have all members of the family (as well as other close contacts) radiologically examined at the City Hospital. Considerable persistence and persuasive skill on the part of the health visitor are sometimes necessary

to gain the full co-operation of the family, but it is interesting to note that, during the year under review, 1,380 contacts were examined. The number of contacts who, during the year, were clinically examined, skin tested, and found to have tuberculosis was 17.

(d) B.C.G. Vaccination.

The following is a copy of the return which was submitted to the Department of Health, giving particulars of the B.C.G. vaccinations performed:—

B.C.G. VACCINATION, 1956.

RETURN FOR PERIOD 1ST JANUARY, 1956, TO 31ST DECEMBER, 1956.

GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1956	
	M.	F.	M.	F.	M.	F.
(1) Nurses	16	289	1	97	1	95
(2) Medical Students . .	48	30	15	12	14	12
(3) Contacts	226	204	176	163	155	148
(4) Special Groups :—						
(a) School leavers . .	855	1,001	413	459	391	449
(b) New born babies .	—	—	—	—	51	49
(5) Others	63	62	17	21	5	13

(e) Mass Miniature Radiography.

11,230 people were x-rayed by the 35-mm. mobile unit in the City of Aberdeen during 1956, but this includes an unknown number of people who work in Aberdeen but reside outwith the City boundaries. This yielded 29 cases of active pulmonary tuberculosis, 75 cases of pulmonary tuberculosis considered to be inactive, and 7 cases of bronchial carcinoma.

(f) Supply of extra nourishment.

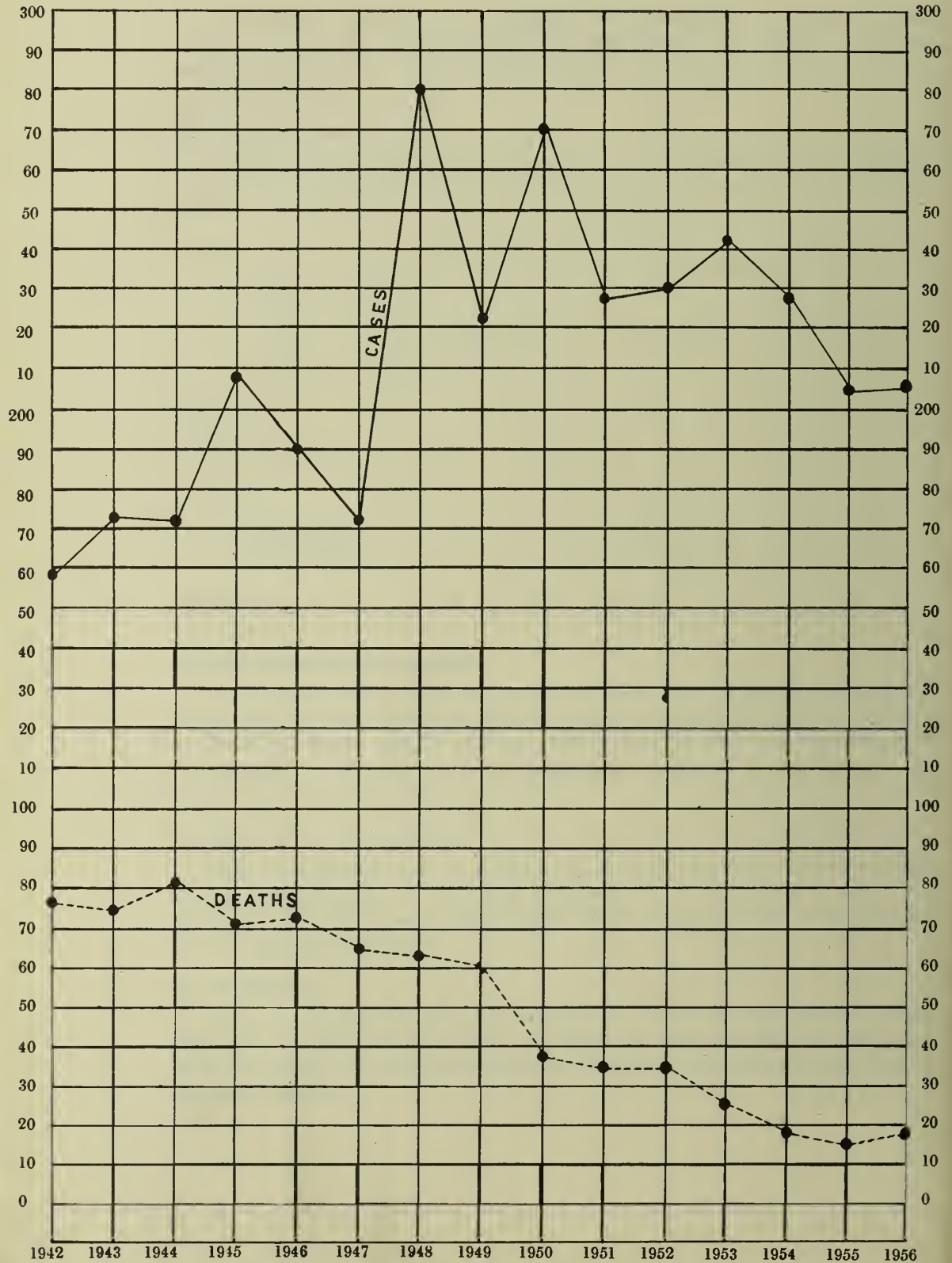
Extra nourishment (such as cod liver oil and milk) is given to necessitous cases on the recommendation of the Chest Physician. It is interesting to note that, during the year, 382 patients received milk free of charge at a cost to the Corporation of approximately £3,050.

(g) Notification.

Table A, on page 95, gives the number of tuberculous cases notified during 1956, and, for comparative purposes, the figures for 1955 and 1954 are also given. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

CITY OF ABERDEEN.

CASES AND DEATHS FROM RESPIRATORY TUBERCULOSIS, 1942-1956.



(h) Tuberculosis Care Committee.

This committee, a voluntary body set up in 1955, continued throughout the year to ease the load which tuberculosis throws on the sufferers and their families. This service is much appreciated.

TABLE A.—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1956.

	NUMBER OF CASES NOTIFIED AS SUFFERING FROM TUBERCULOSIS.								
	AGE-GROUPS.								
	Under 1	1-5.	5-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	Total.
RESPIRATORY.									
1956 Males	1	4	4	34	23	19	24	17	126
1955 Males	2	3	12	26	16	14	29	6	108
1954 Males	2	7	3	8	23	20	54	6	123
1956 Females	—	2	4	23	28	11	7	4	79
1955 Females	1	3	9	38	27	8	7	3	96
1954 Females	1	6	5	6	48	22	15	2	105
NON-RESPIRATORY.									
1956 Males	—	2	—	2	—	1	—	—	5
1955 Males	—	2	3	1	2	1	2	—	11
1954 Males	1	3	—	2	2	—	2	—	10
1956 Females	—	1	2	3	2	1	—	1	10
1955 Females	—	2	2	4	2	1	2	—	13
1954 Females	—	3	2	3	3	3	1	1	16
RESPIRATORY AND NON RESPIRATORY.									
1956 Male and Female	1	9	10	62	53	32	31	22	220
1955 Male and Female	3	10	26	69	47	24	40	9	228
1954 Male and Female	4	19	10	19	76	45	72	9	254

The appended graph shows the notifications and deaths from respiratory tuberculosis during the past few years.

Of the 205 cases of respiratory tuberculosis notified, including 14 transfers, 204 were confirmed. Of the 15 non-respiratory cases notified, including 1 transfer, all were confirmed.

As regards the site of the disease in the 15 cases notified as suffering from tuberculosis other than respiratory, 1 suffered from tuberculosis of the bones and joints (including spinal tuberculosis), 6 from tuberculous meningitis, 3 from tuberculous glands, 2 from abdominal tuberculosis, 1 from genito-urinary tuberculosis, and 2 from other forms of tuberculosis.

The number of persons residing in Aberdeen who, at 31st December, 1956, were known to be suffering from tuberculosis was 2,087—1,970 respiratory and 117 non-respiratory cases.

Table B gives particulars of those who died during 1956, detailing the period which elapsed between notification and death.

**B.—NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH—
YEAR, 1956.**

	RESPIRATORY.		NON-RESPIRATORY.	
	Males.	Females.	Males.	Females.
Number of Persons who died from Tuberculosis	* 8 (11)	* 10 (4)	* — (2)	* — (—)
of whom—				
Not notified or notified only at or after death	1 (2)	2 (—)	— (2)	— (—)
Notified less than 1 month before death	— (1)	1 (—)	— (—)	— (—)
" from 1 to 3 months	— (—)	— (—)	— (—)	— (—)
" " 3 to 6	— (—)	— (—)	— (—)	— (—)
" " 6 to 12	— (—)	— (—)	— (—)	— (—)
" " 1 to 2 years	— (2)	1 (1)	— (—)	— (—)
" " over 2 years	7 (6)	6 (3)	— (—)	— (—)
TOTAL	8 (11)	10 (4)	— (2)	— (—)

* 1955 figures in brackets.

Here are the total deaths from that disease in recent years:—

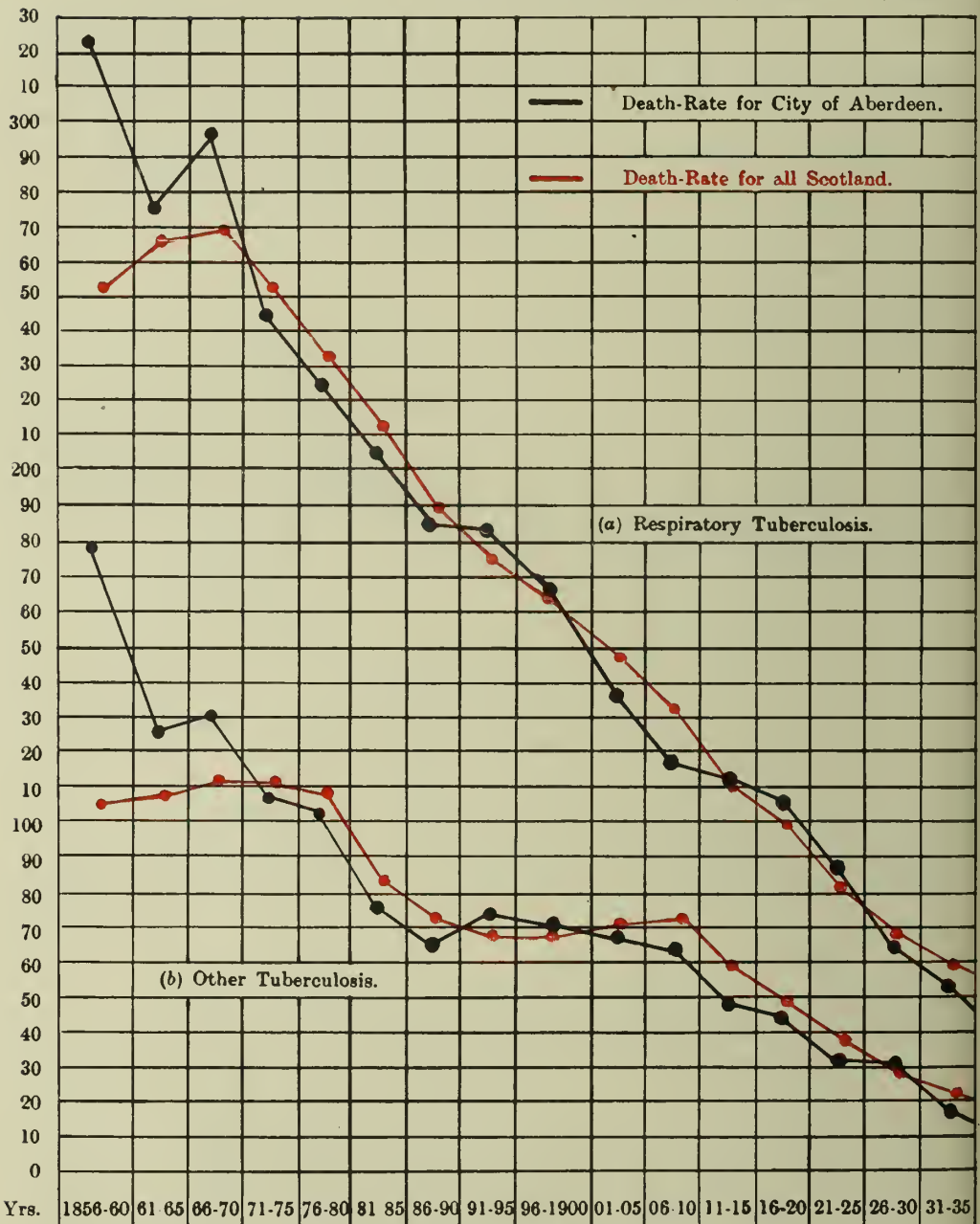
	1951.	1952.	1953.	1954.	1955.	1956.
Respiratory	36	36	26	19	15	18
Non-respiratory	5	4	4	4	2	0

The death-rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1956, 1955, and 1954 are given in the following table:—

	1956			1955			1954		
	Total	Resp.	Other	Total	Resp.	Other	Total	Resp.	Other
All Scotland	0·16	0·14	0·02	0·19	0·17	0·02	0·22	0·20	0·02
Glasgow	0·42	0·38	0·04	0·36	0·33	0·03	0·37	0·34	0·03
Edinburgh	0·11	0·09	0·02	0·12	0·10	0·02	0·20	0·19	0·01
Dundee	0·17	0·14	0·03	0·18	0·15	0·03	0·20	0·19	0·01
Aberdeen	0·10	0·10	0·00	0·09	0·08	0·01	0·12	0·10	0·02

The accompanying chart shows the death-rates since 1856, together with a comparison between Aberdeen and all Scotland.

Deaths per 100,000 of Population. (Civilian)



(a) RESPIRATORY TUBERCULOSIS.

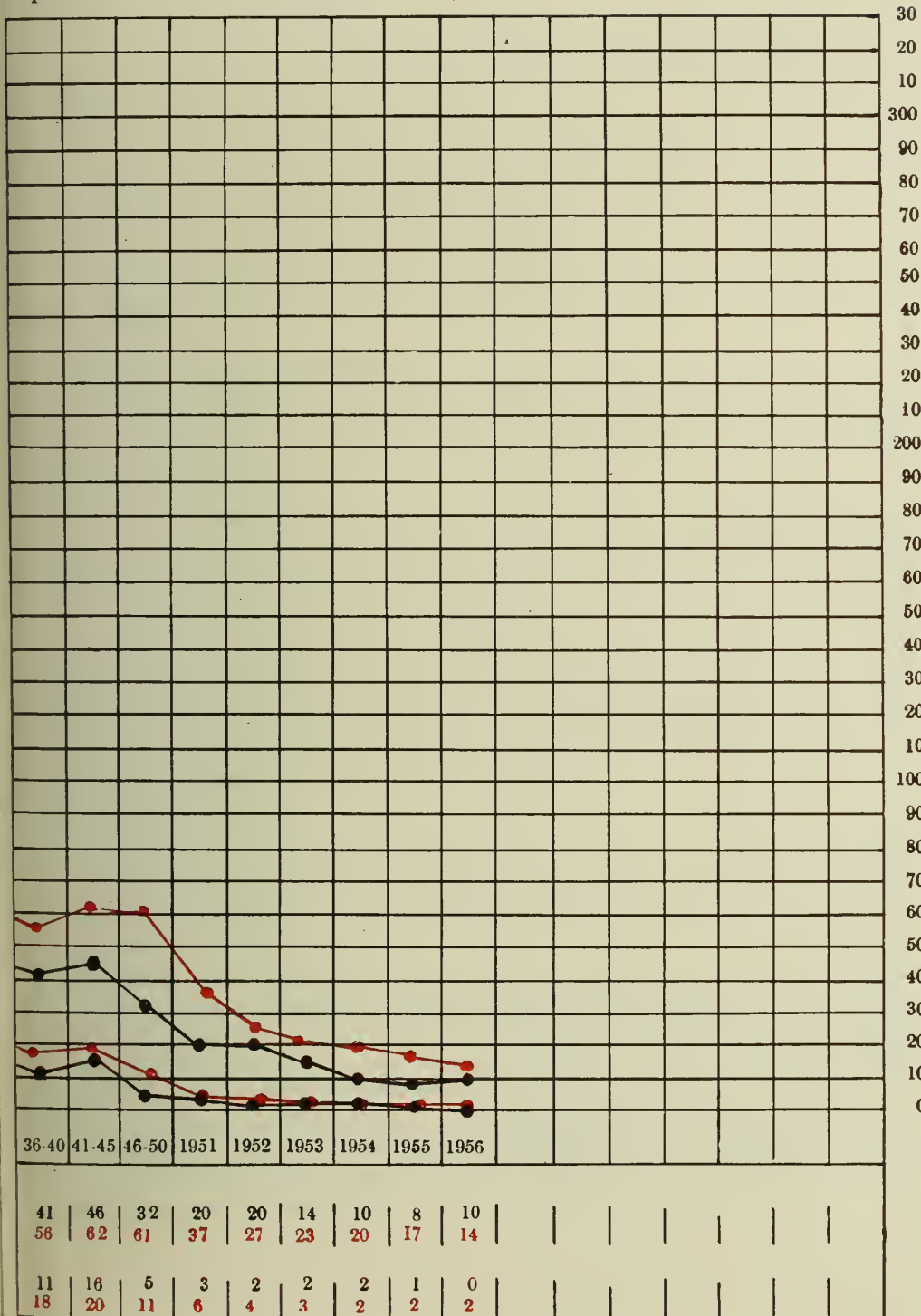
Abdn.	322	274	298	243	223	204	184	181	167	138	116	111	106	88	62	52
All Scot.	253	266	270	254	234	213	190	176	166	148	131	110	99	81	68	59

(b) OTHER TUBERCULOSIS.

Abdn.	179	128	130	107	101	74	67	72	70	69	61	49	43	31	30	17
All Scot.	104	109	112	111	109	83	71	68	69	70	73	59	48	36	28	21

(Corrected for transferred deaths in 1904 and subsequent years.)

Population and Civilian Deaths 1940-1946.)



(B) OTHER DISEASES.

Prevention—General Points.

(1) The measures employed for the specific prevention of diphtheria, whooping cough, tetanus, smallpox, and poliomyelitis have already been described in the chapter on vaccination and immunisation.

(2) Various general measures for the prevention of diseases in children have been outlined in the chapter on maternity and child welfare.

(3) Health education, including the very important aspect of the promotion of mental health, is discussed in a separate chapter.

(4) The prevention of home accidents is also discussed in a separate chapter.

(5) A booklet on food hygiene is described in the chapter on Food Supply and Food Hygiene.

Prevention of diseases in the elderly.

Since prevention, after-care, and welfare are inevitably closely linked in the case of old people, it is convenient to discuss the measures for the health and welfare of the elderly in a subsequent section. However, it may be appropriate to mention two points here:—

(a) The register of elderly persons or couples living alone has amply justified itself. It now contains some 2,000 names, and over 99 per cent. of the 2,320 old people visited by health visitors during 1956 have welcomed the visits, a finding in conformity with that of the two previous years.

(b) The chiropody service has continued to develop, and a full-time chiropodist (appointed in June) is able to undertake only about half the work, the rest being carried out by part-time chiropodists. During the year, 850 persons paid 3,446 visits to the chiropody clinic, and 2,372 visits were paid to 749 persons in their own homes. By contrast, in 1955, 711 persons visited the clinic 2,725 times, and 450 persons were visited in their own homes 1,687 times.

Care and After-Care.

The work of the local health authority has here again been very greatly extended by the National Health Service (Scotland) Act, but, as in so many other fields of the work, shortage of staff has as yet prevented the full implementation of the new duties.

Apart from care and after-care in cases of tuberculosis, it may be relevant to mention here the after-care services that are being developed for the elderly. District nurses refer to the Health and Welfare Department elderly patients whom they have been attending and are ceasing to attend and who, in their opinion, would benefit from visits by health visitors. Similarly, hospital staff refer quite a number of elderly patients on discharge from hospital.

After-care is required (but not yet available) for many patients discharged from hospital, *e.g.*, after being treated for cardiac diseases, peptic ulcer, cancer, and various mental diseases.

14.—CONTROL OF INFECTIOUS DISEASES.

The following table indicates the prevalence of infectious diseases during the year:—

	No. of Cases.		Increase.	Decrease.
	1956.	1955.		
Cerebro-spinal Fever	4	6	—	2
Chickenpox	8	4	4	—
Diphtheria	—	2	—	2
Dysentery	100	262	—	162
Erysipelas	22	18	4	—
Infective Jaundice	—	1	—	1
Measles	53	351	—	298
Acute Influenzal Pneumonia	17	7	10	—
Acute Primary Pneumonia	217	235	—	18
Poliomyelitis	5	10	—	5
Puerperal Fever	8	5	3	—
Puerperal Pyrexia	2	3	—	1
Scarlet Fever	44	69	—	25
Paratyphoid B. Fever	4	1	3	—
Whooping Cough	9	398	—	389

Cerebro-Spinal Fever.

Four cases were notified in 1956, as compared with six in 1955, eight in 1954, and ten in 1953. None of the four cases was fatal.

Chickenpox.

In 1956, eight cases were brought to the knowledge of the department. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

Continued Fever (Undulant).

No cases were notified during the year.

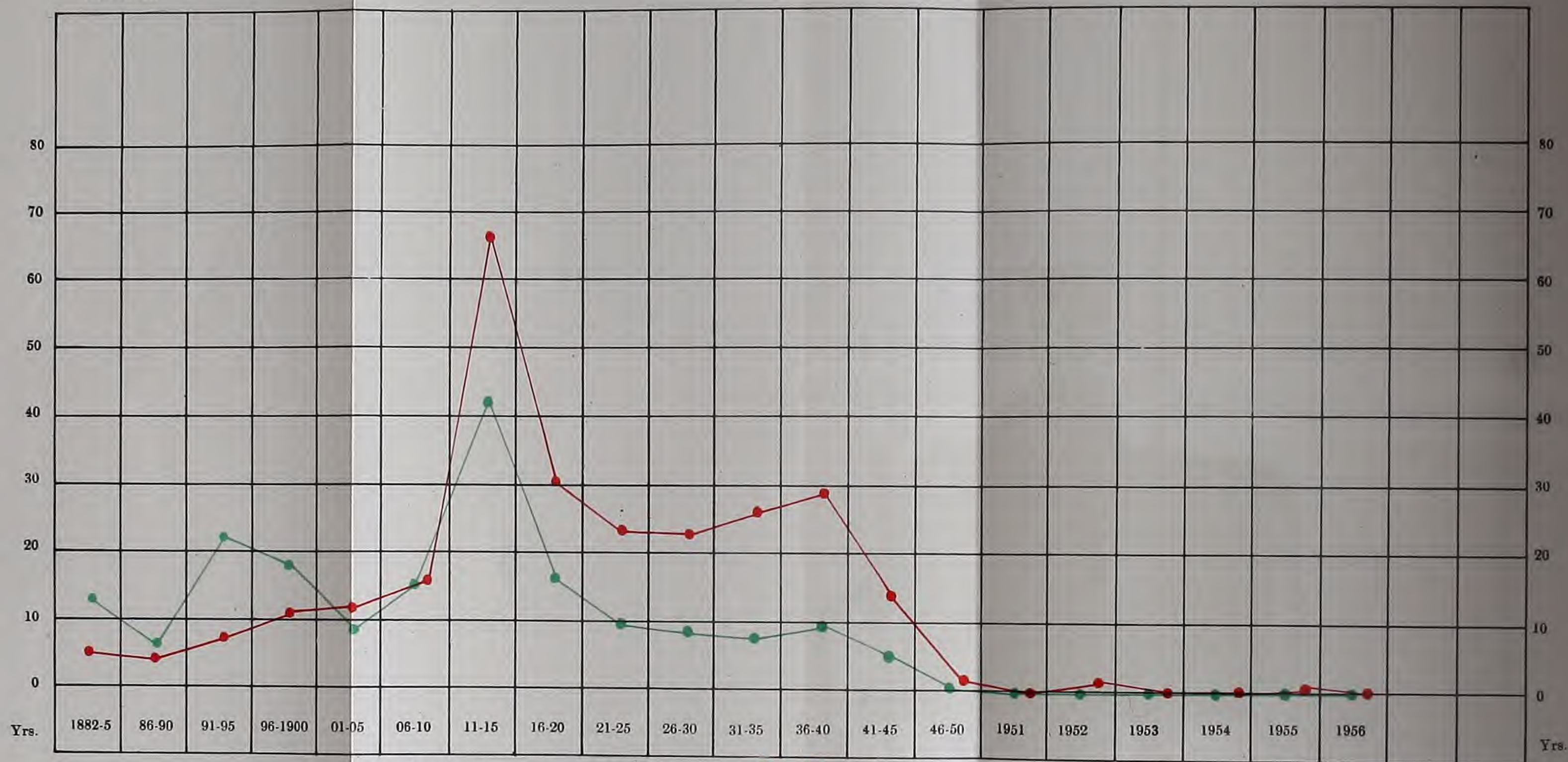
Diphtheria.

There were no cases in 1956.

It may be of interest to set out for preceding years the cases and deaths in five-yearly periods:—

	Cases.	Deaths.
1956	0	0
1951-1955	5	0
1946-1950	86	1
1941-1945	1,148	53
1936-1940	2,548	97

ABERDEEN



DIPHTHERIA — { Attack Incidence per 10,000 of population
Deaths per 100,000 of population } 1882 - 1956: QUINQUENNIAL AVERAGES to 1950.

The tremendous year by year reductions from 586 cases and 21 deaths in 1940 (and even higher figures earlier, *e.g.*, 719 cases and 25 deaths in 1934) to the figures of to-day bear eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941, although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere in this report.

The accompanying chart gives the attack incidence and death rate from 1882.

Dysentery.

In 1956, there were 100 notified cases of this disease as compared with 262 in 1955 and 129 in 1954.

Encephalitis Lethargica.

No cases were notified during 1956.

Erysipelas.

There were 22 cases of erysipelas in 1956, as compared with 18 in 1955 and 33 in 1954. In 1956, one death occurred in a lady of 62 years, suffering also from toxic myocarditis. It is interesting to note that twenty years ago the annual number of cases normally exceeded 100.

Infective Jaundice.

During the year 1956 there were no confirmed cases of infective jaundice, as contrasted with one case in the previous year.

Before the Aberdeen study of infective jaundice in 1934, cases were often not reported. Since the time when that study focussed attention on the disease and thereby ensured more adequate reporting, not a year passed without one or more cases. 1956 is the first year in which the City has been free from the disease. Figures for the last 23 years are given below:—

Year.	No. of Cases.	No. of Deaths.	Year.	No. of Cases.	No. of Deaths.
1934 . .	23	1	1946 . .	6	2
1935 . .	18	1	1947 . .	6	—
1936 . .	16	1	1948 . .	10	3
1937 . .	18	—	1949 . .	11	1
1938 . .	23	2	1950 . .	10	—
1939 . .	23	1	1951 . .	4	2
1940 . .	13	1	1952 . .	10	1
1941 . .	17	3	1953 . .	13	—
1942 . .	10	—	1954 . .	2	—
1943 . .	6	1	1955 . .	1	—
1944 . .	4	—	1956 . .	—	—
1945 . .	4	—			

Leprosy.

This disease has been compulsorily notifiable since 1st September, 1951. No case has been reported in this area.

Malaria.

One fatal case occurred in 1956—a seaman, aged 22 years. In the previous year 3 cases were notified, in 1954 there was 1 case, and in 1953 six cases were notified.

Measles.

Compulsory notification of this disease in Aberdeen was, after a very short trial, discontinued in 1903, and has not as yet been reinstated. General practitioners are, however, encouraged to intimate cases to the department. In 1956, 53 cases were voluntarily intimated by doctors. There were no deaths. Corresponding intimations for previous years were: 1955—351; 1954—72; 1953—247; 1952—801; and 1951—824.

Ophthalmia Neonatorum.

No case was notified in 1956, 1955, or 1954. There was a case in 1953, and this was the only one notified during the last seven years. The virtual eradication of this formerly serious cause of blindness constitutes one of the major triumphs of preventive medicine. Before the second world war the annual number of cases of ophthalmia neonatorum commonly exceeded 100.

Pneumonia, Acute Influenzal.

Seventeen cases were notified in 1956. Four deaths occurred—all elderly persons. In the preceding year, 7 cases were notified, with one death.

Pneumonia, Acute Primary.

During 1956, 217 cases were notified, with 12 deaths, as compared with 235 cases and 11 deaths in 1955. During the ten years 1946-1955, the annual average number of cases was 343, and the annual average number of deaths was 33. Of the 217 cases in 1956, 171, or 79 per cent., received institutional treatment.

Poliomyelitis (Infantile Paralysis).

Five cases of this disease were notified in 1956, as compared with 10 in 1955, 34 in 1954, and 12 in 1953.

In 1956, as in 1955, there were no deaths from this disease. It may be worth while to mention that, in the 79 cases occurring in the years 1952-1956, there were only three deaths.

Puerperal Fever and Puerperal Pyrexia.

Ten cases of puerperal fever and puerperal pyrexia were notified. Eight were confirmed as suffering from puerperal fever. No deaths were registered from this cause.

Two cases were classified as cases of puerperal pyrexia, as compared with 3 in 1955.

All the cases of puerperal fever received institutional treatment in the City Hospital.

It is interesting to note that, in a typical pre-war year (1934), there were 91 cases of puerperal fever and 8 deaths.

Scarlet Fever.

In 1956, 44 cases of scarlet fever were notified, as compared with 69 in 1955 and an annual average of 281 in the decennium 1946-1955. There were no deaths for the eighth consecutive year.

In recent years this disease has assumed a very mild character and has become almost a rarity: it is difficult nowadays to realise that, twenty years ago, a typical description of the amount of scarlet fever in the City would be—2,000 cases and 16 deaths.

Smallpox.

Aberdeen has remained free from smallpox since 1930.

Analysis of the vaccinations carried out in 1956 by general practitioners and at child welfare clinics is given in an earlier section of this report.

Typhoid and Paratyphoid Fevers.

There were no cases of typhoid fever but four cases of paratyphoid fever B. were notified in 1956. In 1955 there was one case of paratyphoid.

Whooping Cough.

On 1st January, 1950, this disease became compulsorily notifiable. The number of cases notified during 1956 was 9, as compared with 398 in 1955. No deaths occurred in 1956. In 1955 there were 4 deaths, including 3 under one year of age.

As indicated elsewhere in this report, whooping cough immunisation among infants and pre-school children is carried out at the various Child Welfare Centres and at home by general practitioners. During 1956, the number of children so immunised was 2,711.

Infections generally.

The following tables deal with the various infectious diseases. Table I shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not. In Table II are given the morbidity and mortality from infectious diseases, classified according to age and to the allocation of patients to institutions for purposes of treatment. In Table III, the cases and deaths are detailed for each of the years from 1946 to 1956.

Arrangements for Laboratory Services.

Until 1948 the Corporation provided an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital and undertakes some biochemical work for the Hospital Board. The arrangement works satisfactorily.

TABLE I.—PROGRESS OF INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS)
DURING TWELVE MONTHS—YEAR, 1956.

Disease.		1956.												Whole Year.
		Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
Cerebro-spinal Fever.	Cases	—	—	3	—	1	—	—	—	—	—	—	—	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Chickenpox	Cases	1	—	2	1	—	1	—	2	—	1	—	—	8
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	—	1	5	—	—	2	1	3	25	15	15	33	100
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Lethargica	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	4	1	—	2	3	2	1	1	2	3	2	1	22
	Deaths	—	—	—	—	—	—	—	1	—	—	—	—	1
Jaundice, Acute	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Infective	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	1	—	—	—	—	—	—	—	—	—	—	—	1
	Deaths	1	—	—	—	—	—	—	—	—	—	—	—	1
*Measles	Cases	—	—	—	—	10	3	4	1	4	2	9	20	53
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia	Cases	—	13	1	—	—	—	1	—	—	—	—	2	17
	Deaths	—	4	—	—	—	—	—	—	—	—	—	—	4
Influenzal	Cases	33	35	23	23	17	17	11	6	7	10	11	24	217
	Deaths	1	1	4	—	2	1	1	—	1	—	—	1	12
Pneumonia, Acute Primary	Cases	2	—	—	—	—	—	—	1	1	1	—	—	5
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Poliomyelitis, Acute	Cases	—	1	—	2	—	—	1	3	1	—	—	—	8
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	1	—	—	—	—	—	1	—	—	—	—	—	2
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	4	2	4	3	4	3	5	1	5	8	2	3	44
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid A.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid B.	Cases	—	—	—	1	—	—	—	3	—	—	—	—	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	—	—	—	1	—	1	—	3	1	—	1	2	9
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	—	—	—	—	—	—	—	2	—	1	1	—	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Total	Cases	46	53	38	33	35	29	25	26	46	41	41	85	498
	Deaths	2	5	4	—	2	1	1	1	1	—	—	1	18
Influenza, excl. Influenzal Pneumonia	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—

*Not compulsorily notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES
(EXCLUDING TUBERCULOSIS) DURING 1956.

DISEASE		NO. OF CASES AND DEATHS AT VARIOUS AGE-PERIODS									Cases receiving Institutional Treatment	Cases not receiving Institutional Treatment
		At all Ages	YEARS									
			Under 1	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 65	65 and upwards		
Cerebro-spinal Fever	Cases	4	1	3	—	—	—	—	—	—	4	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
*Chicken Pox...	Cases	8	—	2	3	2	1	—	—	—	8	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	100	2	50	23	4	7	5	8	1	18	82
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica...	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	22	—	1	1	—	2	4	8	6	8	14
	Deaths	1	—	—	—	—	—	—	1	—	1	—
Infective Jaundice ...	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	1	—	—	—	1	—	—	—	—	1	—
	Deaths	1	—	—	—	1	—	—	—	—	1	—
*Measles	Cases	53	3	26	22	2	—	—	—	—	26	27
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	17	—	—	—	—	—	3	5	9	3	14
	Deaths	4	—	—	—	—	—	—	—	4	—	4
Pneumonia, Acute Primary	Cases	217	22	25	8	6	12	13	47	84	171	46
	Deaths	12	1	—	—	—	—	1	1	9	11	1
Poliomyelitis, Acute	Cases	5	2	—	1	2	—	—	—	—	4	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	8	—	—	—	2	4	2	—	—	8	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	2	—	—	—	—	1	1	—	—	—	2
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever...	Cases	44	—	14	22	5	3	—	—	—	9	35
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Small-pox	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid B	Cases	4	—	—	—	2	1	—	1	—	4	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough	Cases	9	2	7	—	—	—	—	—	—	3	6
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	4	—	1	—	1	1	—	1	—	—	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Total	Cases	498	32	129	80	27	32	28	70	100	267	231
	Deaths	18	1	—	—	1	—	1	2	13	13	5

* Not compulsorily notifiable.

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING
TUBERCULOSIS, DURING EACH YEAR FROM 1946 TO 1956.

Disease.		1956	1955	1954	1953	1952	1951	1950	1949	1948	1947	1946	ANNUAL AVERAGE 1946 to 1955.
Cerebro-Spinal	Cases	4	6	8	10	7	24	14	9	5	12	28	12.3
Fever . . .	Deaths	0	0	1	0	0	0	0	1	2	2	0	0.6
*Chickenpox . .	Cases	8	4	11	12	48	16	26	23	62	23	60	28.5
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Continued Fever (Undulant) . .	Cases	0	0	2	0	1	0	9	4	1	3	4	2.4
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Diphtheria . .	Cases	0	2	0	0	3	0	2	3	4	9	68	9.1
	Deaths	0	0	0	0	0	0	1	0	0	0	0	0.1
Dysentery . .	Cases	100	262	129	110	14	225	67	34	137	13	100	109.1
	Deaths	0	0	0	0	0	1	0	0	1	0	0	0.2
Encephalitis . .	Cases	0	0	0	0	0	0	1	0	0	0	0	0.1
Lethargica . .	Deaths	0	0	0	0	0	0	1	0	0	0	0	0.1
Erysipelas . .	Cases	22	18	33	27	32	23	37	48	64	65	104	45.1
	Deaths	1	0	0	1	0	1	0	0	0	0	2	0.4
Infective Jaundice	Cases	0	1	2	13	10	4	10	11	10	6	6	7.3
	Deaths	0	0	0	0	1	2	0	1	3	0	2	0.9
Leprosy . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Malaria . . .	Cases	1	3	1	6	2	1	8	9	4	9	23	6.6
	Deaths	1	0	0	0	0	0	0	0	0	0	0	0.0
*Measles . . .	Cases	53	351	72	247	801	824	26	402	199	527	500	394.9
	Deaths	0	1	0	0	0	1	1	1	1	3	0	0.8
Ophth. Neonatorum	Cases	0	0	0	1	0	0	0	1	3	7	6	1.8
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Plague . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Pneumonia, Acute	Cases	17	7	23	5	18	10	32	10	7	4	13	12.9
	Deaths	4	1	2	1	5	2	7	4	3	2	7	3.4
Pneumonia, Acute Primary . . .	Cases	217	235	294	263	301	242	422	443	444	404	379	342.7
	Deaths	12	11	19	9	13	43	58	41	42	53	38	32.7
Poliomyelitis, Acute	Cases	5	10	34	12	18	4	36	3	5	48	1	17.1
	Deaths	0	0	1	1	1	0	2	0	0	6	0	1.1
Puerperal Fever	Cases	8	5	2	26	17	13	35	46	25	42	52	26.3
	Deaths	0	0	0	1	0	1	9	1	0	1	1	0.5
Puerperal Pyrexia	Cases	2	3	10	13	13	10	11	13	34	33	26	16.6
Scarlet Fever . .	Cases	44	69	178	239	314	299	513	275	252	205	465	280.9
	Deaths	0	0	0	0	0	0	0	0	1	0	0	0.1
Smallpox . . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Tuberculosis, Respiratory . .	Cases	205	204	228	243	230	226	270	222	279	172	190	226.4
	Deaths	18	15	19	26	36	36	38	60	62	65	71	42.8
Tuberculosis, Non- Respiratory . .	Cases	15	24	26	31	30	31	31	28	37	53	50	34.1
	Deaths	0	2	4	4	4	5	5	6	8	12	12	6.2
Typhoid and Para- typhoid Fevers	Cases	4	1	16	3	10	4	2	4	30	6	2	7.8
	Deaths	0	0	0	0	0	0	7	0	0	1	0	0.1
Typhus Fever . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Whooping Cough	Cases	9	398	284	175	549	551	449	58	194	176	151	298.5
	Deaths	0	4	0	0	0	3	0	0	2	5	3	1.7
Influenza, excl. Influenzal Pneumonia . .	Deaths	0	0	1	2	0	7	6	6	1	0	2	2.5

*Not compulsorily notifiable.

15.—MENTAL HEALTH.

Before the beginning of 1956 the Corporation's mental health services had undergone very considerable development: a Senior Assistant Medical Officer had been appointed at the end of 1953 with duties primarily in the mental field, and in 1954 and 1955 some forty-six health visitors had attended intensive post-qualification courses in mental health to equip them more fully in their work in the promotion of mental health and the prevention of diseases of emotional and mental origin. (It may be noted in passing that the health visitors now being trained receive fairly adequate instruction in psychology and mental health—a total of about thirty lectures supplemented by case-studies and tutorials, and superimposed on some rudimentary information about mental aspects of disease now included in the general nursing training.)

1956 was a year of consolidation, hindered to some extent by shortage of health visitors.

Most of the chapter that follows deals not with mental health but with mental disease, but it will be appreciated that the prevention or reduction of the psychoneuroses, psychosomatic diseases, anti-social behaviour, juvenile delinquency and so forth. constitute one of the main tasks—probably indeed the biggest task—of the Health and Welfare Department. Since most of that prevention or reduction is undertaken by health visitors in the home and by medical officers and health visitors in the clinic, reference to it is more appropriately made in the sections of the report dealing with Health Visiting, Maternity and Child Welfare, and the School Health Service.

I. ADMINISTRATION.

(1) Duties.

Although the Corporation have no responsibility for the institutional care of the mentally sick, they are responsible for each of the following aspects:—Prevention of mental disease; ascertainment, care and after-care of mental defectives and mentally ill persons in their own homes; and provision of suitable training and occupation for mental defectives over the age of 16 years and for ineducable defectives under that age.

(2) Committee Responsible.

The responsible Committee is the Health and Welfare Committee, except in the case of educable defectives under guardianship and aged 5 to 16 years. The latter are the responsibility of the Education Committee.

(3) Number and Qualifications of Staff Employed.

(a) *Medical Officers.*—The certification of insane persons requires two certificates. In general, the first of these certificates is given by the Medical Officer for Mental Health of the North-Eastern Regional Hospital Board, or, in his absence, by one of

two other specialists in mental disease whose services have been made available to general practitioners by arrangements with the Executive Council. The second certificate is usually completed by the general practitioner normally attending the patient.

As indicated above, numerous duties in regard to prevention, ascertainment, supervision, and after-care devolve on the medical officers of the Health and Welfare Department. The Medical Officer of Health, the Deputy Medical Officer of Health, the Senior Assistant Medical Officer, and several of the Departmental Medical Officers hold the post-graduate certificate in mental assessment.

(b) *Psychiatric Social Worker*.—The Corporation have not appointed any psychiatric social worker. Until the middle of 1952, an arrangement operated whereby a psychiatric social worker employed by the University Department of Mental Health was available for a limited amount of time. When the last holder of that post left, the University decided for the present not to replace her. On occasions, a psychiatric social worker from the Regional Hospital Board visits local authority cases by special request.

(c) *Health Visitors*.—As mentioned above, considerable duties in respect of prevention of emotional and mental diseases, care and after-care devolve on the health visitors, especially the 49 health visitors in charge of districts of the City. At the end of the year, 68 were employed and there were 17 vacancies on the establishment.

(d) *Other Mental Health Workers*.—At present, none is employed.

(e) *Duly Authorised Officers*.—The Senior Assistant Welfare Officer has been designated authorised officer. His duties as authorised officer are (1) to make arrangements for the detention of persons apparently of unsound mind who have no relatives or friends willing or able to take such action; (2) to ensure that adequate domestic arrangements have been made when it is proposed to discharge insane persons from mental hospitals; (3) on the instructions of the Medical Officer of Health, to take steps to remove, pending the presentation of a petition, a supposed defective who is neglected, cruelly treated, or without visible means of support, to a place of safety; and (4) to deal with certain types of mentally handicapped children. The Senior Assistant Welfare Officer is assisted by three Assistant Welfare Officers, who are all well versed in mental health certification procedure, &c.

(f) *Occupation Centre Supervisors, &c.*—As yet, none is employed. (The Corporation some time ago approved of the provision of an occupation centre for the mentally handicapped, but suitable premises have not yet been secured.)

(4) Co-ordination.

Close liaison is maintained with the North-Eastern Regional Hospital Board and with the Board of Management for the Mental Hospitals.

On the one hand, where a certified defective is placed under guardianship or is boarded out or liberated on licence from a mental hospital, supervision, although legally a matter for the hospital authorities, is undertaken by members of the Corporation staff. On the other hand, in carrying out duties relating to mental illness and mental deficiency, the medical officers of the Corporation have the valuable

co-operation and help of the Regional Hospital Board Medical Officer for Mental Health, of the Professor of Mental Health, and of the Physician Superintendents of Kingseat Mental Hospital and the Aberdeen Royal Mental Hospital. The co-operation is good and is appreciated on both sides.

(5) Duties delegated to Voluntary Associations.

No duties in relation to mental cases have been delegated to any voluntary associations, all duties being carried out by members of the Health and Welfare Department, with the exception of such duties as are, by mutual agreement, carried out by officers of the Regional Hospital Board (as mentioned above).

(6) Training of Staff.

Arrangements made have included (a) the provision of the post-qualification courses for mental health for health visitors, mentioned above, and (b) the sending of an occasional medical officer to mental deficiency courses.

II. AMOUNT OF WORK UNDERTAKEN.

1. Under Section 27 of the National Health Service (Scotland) Act.

(a) *Measures for prevention of Mental Illness.*

(i) *Health Education by Health Visitors and by Departmental Medical Officers.*

This constitutes an important and increasing part of the normal health education work undertaken by the department. As more and more of the physical diseases are conquered, the amount of attention focussed on mental health is being proportionately enlarged.

The particular importance of the rôle of the family health visitor—an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor and social adviser—in the prevention of the “break-up” of the family, with its consequent bad effects on the physical and even more on the mental health of children, and in the prevention of mental ill-health in general was emphasised in D.H.S. Circular No. 77/1954.

(ii) *Attempts to assist families placed in situations of abnormal physical or mental or financial strain.*

For households under physical strain, home helps are available, as indicated elsewhere in this report. Again, physical strain on parents is frequently relieved by admission of young children to day or (less often) to residential nurseries. Financial strain is again often relieved by the same means, the mother being, for a time, enabled to undertake whole-time or part-time work with a view to obtaining sufficient money to permit of the paying off of debts, &c.

The health visitors give a vast amount of useful advice and guidance on family budgeting and on general domestic problems, and there is, in addition, a good liaison with the National Assistance Board and with the various voluntary societies.

Another factor of some assistance to families in situations of abnormal physical, mental, or financial strain is the existence of a Joint Committee to deal with measures for the assistance of children neglected in their own homes. This Committee, by co-ordinating the efforts of health visitors and school nurses, school welfare officers, the National Society for the Prevention of Cruelty to Children, the National

Assistance Board, and so on, as well as of bodies like the Council of Social Service, can sometimes find a practical means of relieving an intolerable strain on households. In addition, this co-ordinating mechanism makes for economy in that the number of persons concerned with each of these difficult families is kept down to a minimum.

(b) Care and After-care of the Mentally Ill and Mental Defective.

All patients released on probation from mental institutions and residing within the City or boarded out within the City are visited regularly by the authorised officer or one of the assistant welfare officers and are also medically supervised by a medical officer versed in mental health.

There is still considerable inadequacy of institutional accommodation for mentally defective persons who are in need of institutional care and supervision, and there is also a grave need for an occupation centre for defectives living at home. Suitable premises have not yet become available to meet the latter need, and, by arrangement with the Education Department, certain children leaving the special schools at 16 years of age may continue to attend the occupational centres run by the Education Department, a nominal fee being levied on the Health and Welfare Department in respect of the services provided.

2. Under Lunacy Act by Duly Authorised Officer and by Medical Staff.

The work undertaken under the Lunacy Act includes advice and guidance on budgeting and general domestic problems, reference to psychiatric clinic so as to secure early preventive treatment, where necessary; close liaison between general medical practitioners and psychiatric specialists and the Health and Welfare Department so as to ensure help of any nature required for mentally sick persons, completing and negotiating claims of all types of statutory benefits under the welfare, insurance, and sundry pensions Acts; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation so as to allay any anxiety over such personal responsibilities which might otherwise retard the desired early improvement and recovery of patients; ensuring the proper care and supervision of all patients boarded out under guardianship and on probation or licence from mental institutions; and securing the certification of patients in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and the various Lunacy Acts.

The following is a short statement of the cases dealt with by the department during the year:—

Number of mental cases dealt with in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947, and Lunacy Acts.

	Males.	Females.	Total.
Cases fully certified under the Lunacy Acts, following medical examination	61	82	143
Cases admitted as voluntary boarders, following medical examination	59	52	111
Cases where no action was recommended following medical examination	5	10	15
	<hr/> 125	<hr/> 144	<hr/> 269

Number of patients on probation from mental hospitals who are under supervision.

Males.	Females.	Total.
6	5	11

Number of mental patients boarded-out from mental hospitals under private guardianship who are under care and supervision.

Males.	Females.	Total.
6	2	8

Number of patients on licence from certified institutions under care and supervision.

Males.	Females.	Total.
2	—	2

Number of reports to physician superintendents on home conditions prior to release of patients on probation, in terms of the 9th Schedule of the National Health Service (Scotland) Act, 1947.

Mental Deficiency and Lunacy (Scotland) Acts, 1913-1940.

	Males.	Females.	Total.
	4	3	7
Number of cases reported by the Education Department	8	1	9
Number of cases committed to certified institutions by the department	12	12	24

Number of cases under guardianship as at 31.12.1956.

In the City	11	4	15
Outwith the City	7	6	13

(There were, at the end of 1956, 55 mentally-handicapped persons in the City awaiting admission to certified institutions.)

16.—WORK UNDER NURSERIES AND CHILD-MINDERS' REGULATION ACT.

The Nurseries and Child-Minders' Regulation Act, 1948, which came into operation on 30th July, 1948, empowers local authorities to supervise (i) nurseries where children up to school age are looked after for a day, or for longer periods not exceeding six days, and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

There were no applications for registration during the year.

17.—SCHOOL HEALTH SERVICE.

The continued efficiency of any service depends to a considerable extent on periodical assessment of its aims and methods—to determine, for instance, what alterations are demanded by changes in the needs of the community or by advances in scientific knowledge. The School Health Service, occupying a position intermediate between ordinary health services and ordinary education services, tends to receive less than its share of such assessments.

Professional workers in the field of health (*e.g.*, public health medical officers and health visitors) generally give pride of place to the infant and pre-school child: the first five years have for long been recognised as the period of greatest vulnerability to physical diseases and of maximum importance for laying the foundations of a good or bad physical constitution, and it is now appreciated that these years are also the time when the child learns “the alphabet of living,” the period in which the personality is formed, and the years of supreme importance for the avoidance or production of subsequent emotional instability, antisocial behaviour, and neurotic and psychosomatic diseases. Again, with the rapid ageing of the population, health workers can easily become preoccupied with the manifold health and social problems of elderly people. There is therefore a temptation each year to continue the School Health Service on its previous lines without any appraisal of its efficacy—a temptation that is all the stronger in these days of continued severe shortage of professional staff in health departments.

Similarly, professional workers in the field of education (*e.g.*, school teachers) may not unnaturally tend to think of the imparting of information on “academic” subjects as their main concern, and to feel that school medical inspections, health surveys, individual health counselling, and health education are sidelines only vaguely related to the primary functions of the school.

It may therefore be worth while to devote the first few pages of this report to a consideration of the functions and functioning of the School Health Service, and to start by setting down three points of importance to everyone concerned with the school child:—

(1) Nearly forty years ago, the United States Commission on the Reorganisation of Secondary Education designated health as the first of the seven cardinal objectives of education, a designation that was in essence confirmed in that country by the 1947 Commission on Higher Education. Surely, it is also true in Britain that mental and physical health is the first of the cardinal objectives of education.

(2) Unsatisfactory bodily or mental health interferes with a child’s ability to profit fully from the education provided. Unless due attention is paid to health, the achievement of other goals will be rendered more difficult or even impossible.

(3) The community contains, in addition to productive workers, such non-productive groups as (*a*) pre-school and school children (enlarged numerically by the raising of the school leaving age), (*b*) students in training (and the training for many occupations is tending to extend), (*c*) old age pensioners (a steadily growing army), (*d*) persons not working by reason of physical illness, mental illness, antisocial tendencies, &c., and (*e*) persons employed to care for or control members of the previous group or their dependants—*e.g.*, doctors, nurses, hospital domestics,

policemen, warders, probation officers, children's officers, and so forth. Unless we are to reverse the tendencies for groups (*a*) and (*b*) to increase through higher educational standards and better educational facilities, or unless we are to arrest the steady increase of group (*c*) by drastically altering retirement ages, we must seek to reduce the numbers in group (*d*) and, consequentially, in group (*e*). The obvious way to achieve such reduction is by sustained attention to the health and health education of both pre-school and school children, so that children leave school not only in a state of physical, mental, and emotional health, but also prepared and ready to live healthily and aware that maintenance of health is a duty to themselves and to the community of which they are a part.

SOME FUNCTIONS OF SCHOOL HEALTH SERVICE.

In the list of functions given below the earlier points are those in which the School Health Service must play the leading rôle and the later ones are those in which its rôle, although important, is not necessarily dominant.

1. *Appraisal of health status of pupils.*—Health appraisal has been defined as—
 “That phase of the school health service which seeks to assess the physical, mental, emotional, and social status of individual pupils and school personnel through such means as health histories, teachers’ and nurses’ observations, screening tests, and medical, dental, and psychological examinations.”

Clearly this is a primary function, since defects cannot be rectified and unhealthy attitudes or habits cannot be corrected until the health status of the individual has been assessed. While accurate assessment demands full use of all available relevant material (*e.g.*, child welfare record cards in the case of entrants, information supplied by teachers, &c.), it must rest mainly on the medical examinations (conducted routinely at the ages of 5, 9, and 13 years and at other ages by special request) and on the health surveys carried out by the school health visitors (ideally, each child being inspected every term). Clinical and psychometric investigation must, of course, be available to supplement these examinations and surveys where desirable.

2. *Counselling of pupils and parents concerning appraisal findings.*—An American definition of such counselling is—

“The procedures by which nurses, teachers, physicians, guidance personnel, and others interpret to pupils and parents the nature and significance of a health problem and aid them in formulating a plan of action which will lead to solution of the problem.”

The writer would agree with the American experts that teachers and medical officers have a part to play in counselling, and he would also agree in placing the school health visitor first, since her specialist training equips her particularly well for this duty.

3. *Advising teachers about appraisal findings, e.g.*, advising about pupils whose educational programmes may need modifications in consequence of physical or emotional disorder, suggesting the positioning in class of children with mild visual or auditory defects, discussing the attitudes most likely to produce beneficial results

in the case of children with behaviour problems of a nature insufficiently serious to warrant reference to the Child Guidance Clinic, &c.

4. *Linking home and school.*—One of the important functions of the school health visitor is, or should be, to form a link between the two sets of influences to which the child is subjected, and, in general, to try to prevent these influences from operating in opposed directions. Included under this head is the very important task of informing the teacher, wherever the health visitor deems the information desirable, about abnormal or detrimental factors in a pupil's home background and discussing with the teacher how the school can best counteract or neutralise these factors.

5. *Correction of remediable defects.*—The School Health Service must, of course, continue to provide facilities for certain forms of treatment, *e.g.*, dental clinics, eye clinics, and minor ailments clinics. For other forms of treatment, available under the National Health Service Act, it is the duty of the School Health Service not merely to advise the parent about the desirability of treatment and, where necessary, to communicate with the appropriate general practitioner, but also to follow up the case to ensure that treatment is in fact sought and secured.

6. *Health education in schools.*—School health education may be defined as—

The process of providing learning experiences leading to the formation of desirable habits, attitudes, conduct, and appreciations in physical and mental health.

Health education must, of course, do more than simply teach what mental, emotional, social, and physical health is; it must also help children to live healthily both during their school careers and later.

Some people may argue that health education in school should be regarded as a duty devolving solely on teachers, but (*a*) the school medical inspections and the health visitors' health examinations should themselves be important educational experiences for the pupils, and much of their educational value will be lost if the medical officers and health visitors conducting them have no link with the more formal aspects of health teaching, and (*b*) if the formal teaching of health is entrusted solely to persons who have no occasion to visit the homes of the people and to study individual problems of emotional and social health at close quarters, the teaching may well lose vitality and become increasingly divorced from life as the child experiences it. Therefore, school doctors and health visitors should participate in the planning and implementing of school health programmes.

7. *Participation in the health care and education of handicapped children.*—Clearly, the medical officer and health visitor are mainly concerned with "health" and the teacher is mainly concerned with "education," but co-operation is essential to prevent the extremes of the illiterate adolescent (whose health has been safeguarded to the detriment of his education) and the well-educated physical or emotional wreck (whose schooling has been achieved at the cost of his health).

8. *Provision of a healthy environment, e.g.*, advice about lighting, heating, ventilation, washing, and sanitary facilities; advice about school meals; measures

for the prevention of communicable diseases; advice about prevention of accidents; advice about first-aid and supervision of appliances and equipment for first-aid; advice about playgrounds and recreational facilities, &c.

Many minor functions could be mentioned—*e.g.*, prevention of needless absenteeism, advice to school leavers about occupations for which they are physically or temperamentally unsuited, research throughout the entire field of child health, and so forth—but consideration of the eight points listed above should suffice to indicate the strength and weakness of the present service.

THE FUNCTIONING OF THE SERVICE.

The actual functioning of the Service can be considered under the same headings, but—since most (though perhaps not all) of its weaknesses are attributable to shortages of staff—two additional headings will be included, Staffing and Staffing Policy.

1. STAFFING.

(a) *Medical Officers.*—The policy in recent years has been to appoint medical officers with appropriate post-graduate qualifications and experience to general duties in the Health and Welfare Department (including the School Health Section). All vacancies in the establishment have at last been filled, and the medical staff of the School Health Service in 1955-56 was equivalent to 4 6/11ths full-time school doctors, or one for every 6,764 children.

The medical staffing, while a shade less generous than in some areas, has now reached a standard of reasonable adequacy.

(b) *Dental Officers.*—During the year the resignation of a part-time dental officer reduced the staff available for all dental work from 4 3/11ths to 3 7/11ths, as compared with an authorised establishment of 7.

It is maintained in some quarters that even an establishment of 7 dentists is insufficient for a school population of 30,754, and that Aberdeen's real need is 10 (*i.e.*, one for every 3,000 school children). It is important, however, to appreciate that dental officers, in the main, undertake treatment and not prevention, and that the number of dentists really required will vary inversely with the strength of the preventive service. Thus, if the preventive services contrived greatly to reduce the incidence of dental caries (*e.g.*, by successful advice about diet, especially sweet-eating, and about the hygiene of the mouth, supplemented perhaps by fluoridation of water), Aberdeen might manage satisfactorily with 4 or 5 dental officers; and if the preventive services collapsed completely, the City would need considerably more than the 10 dentists suggested by the theoretical standard. The writer knows, for instance, of one area, with a population just over one-half of that of Aberdeen, very badly staffed in respect of health visitors, and actually employing—and appearing to need—10 dental officers.

There is certainly a shortage of dental officers in Aberdeen, but it is difficult to assess the exact size of the shortage.

(c) *School Health Visitors.*—To prevent needless breaks in the health supervision of children at the age of school entry, the work of school nurses is undertaken by

the Corporation's health visitors—a combination of duties that is expressly advocated in the 1956 Report of the Working Party on the Recruitment, Functions, and Training of Health Visitors.

Expressed in terms of full-time school nurses, the health visiting staff in the middle of the school year amounted to 10·8 officers, or roughly one for every 2,800 pupils. (It may be mentioned for comparative purposes that in 1955 Glasgow had one school nurse for every 2,225 pupils, and that in urban areas in Sweden the recognised standard is one full-time school nurse, with special post-graduate training, for a maximum of 2,000 pupils.)

There is, therefore, a very grave shortage of health visitors. The Corporation has secured the sanction of the Secretary of State for Scotland for an ultimate establishment of 100 health visitors and has set an *interim* target of 85 (about 70 of whom would devote approximately 20 per cent. of their time to the School Health Service), but there are no immediate prospects of filling the vacancies; the Working Party on Health Visitors has estimated that (on a standard that certainly does not err on the side of generosity) Britain needs 1,100 new health visitors annually, as compared with about half that number at present completing their post-qualification training in any one year.

(d) *Ancillary Workers*.—An orthoptist and an audiometrician were employed throughout the year, although the latter resigned at the end of the year and advertisement failed to attract any applicants. A physiotherapist was added to the authorised establishment during the year (and it may well be that the ultimate requirement of the entire Health and Welfare Department is 2 or even 3 physiotherapists) but there were no applicants when the post was first advertised.

2. STAFFING POLICY.

(a) *Long-term Policy*.—The Corporation is willing enough to fill the vacancies on its establishment when suitably qualified candidates appear; but—apart from certain possibilities which have already formed the subject of a special report—the filling of the vacancies depends primarily on the raising of salaries nationally. For example, it has to be appreciated that an intending health visitor has to spend three years in full-time nursing training, a further period in full-time midwifery training, about a couple of years in consolidating her clinical training as a hospital staff nurse or ward sister or as a district nurse, and then (after passing a selection interview and test) a further period—in most training schools an academic year—in full-time training for the health visitor's certificate: as the Society of Medical Officers of Health put it—

“A Health Visitor's training is not markedly inferior in length or intensity to that of a dentist, but a Health Visitor received less than half the salary that a local authority dental officer was paid even before the recent increase in dental officers' remuneration.”

Similarly, it has to be appreciated that the top-ranking posts in health visiting (those of Principal Health Visitor Tutors and of Superintendent Health Visitors of

large authorities) are remunerated less highly than the basic grade posts in certain other professions. Again, while physiotherapists are rightly paid less than health visitors (who have a much longer training), the salaries of physiotherapists compare very badly with those of sanitary inspectors and primary school teachers. Until all these anomalies are rectified at national level, the existing grave shortages will inevitably continue to the detriment of the health of the community.

(b) *Dilution as a Temporary Measure.*—Dilution by less highly trained persons is sometimes suggested as a means of reducing shortages of professional staff. The Corporation has already introduced a measure of dilution (*e.g.*, by employing a nurse without post-qualification training at Beechwood School), but there is a limit to the extent to which dilution can be employed: beyond that limit, the introduction of untrained or partially trained substitutes can endanger the health of the people.

3. APPRAISAL OF HEALTH STATUS OF PUPILS.

Health appraisal in 1955-56 was adequate: *e.g.*, practically every pupil had two health surveys by a health visitor, pupils of the prescribed age-groups were medically examined, school entrants were given an additional rapid examination immediately after their initial entry, all special cases referred by parents or teachers were examined, and 19,425 children were dentally inspected, while appropriate specialist services were available at need.

Two minor points may, however, be mentioned:—

(a) If numbers of staff permitted, it would be desirable to have each child inspected by a health visitor each term so that minor deviations from health (*e.g.*, slight malnutrition or excess fatigability or nervousness) could be detected at an even earlier stage; and it would also be desirable to have every child dentally inspected each year.

(b) While most teachers unhesitatingly referred for examination pupils whom they suspected to be suffering from physical disease, at least some teachers did not appear to realise that medical officers and health visitors could also give useful advice in connection with behaviour problems and emotional disorders, especially those not sufficiently marked to warrant reference to the Child Guidance Clinic. The blame for such non-realisation does not necessarily rest with the teachers involved: it may well be that members of the School Health Service have omitted to draw attention to the fact that they are just as concerned with mental and emotional deviations from normality as with physical abnormalities: after all, the school medical officer and school nurse of the pre-war era were primarily interested in physical health and environmental hygiene, and it is only in recent years that health visitors and public health medical officers have begun to receive really satisfactory training in developmental psychology and allied subjects.

4. COUNSELLING OF PUPILS AND PARENTS CONCERNING APPRAISAL FINDINGS.

Both medical officers and health visitors undertook such counselling, particularly at the time of school medical inspections (at which the number of parents present continued to be high). Yet it cannot be gainsaid that adequate counselling often

necessitates visits to the home and the number of home visits paid by health visitors appears insufficient—a consequence, of course, of gross shortage of staff.

5. ADVISING TEACHERS ABOUT APPRAISAL FINDINGS.

In many cases full discussion and explanation took place, but there are schools where the medical officer or health visitor on the one hand and the class teacher on the other hand seldom conferred except for a brief mention of physical defects or problems of cleanliness. Liaison has been improving steadily in recent years but further improvement is needed.

6. LINKING HOME AND SCHOOL.

The school health visitor cannot act as a link between home and school unless she actually visits the home. Such visiting is particularly important during the first two years of school life, and, despite staff shortages, efforts have constantly been made to increase home visiting. In this connection, it may be mentioned that the policy of decentralisation (described in the Report of the Medical Officer of Health for 1955) has proved of considerable value in decreasing the time spent by health visitors in travelling.

7. CORRECTION OF REMEDIABLE DEFECTS.

In this field the Service has functioned adequately, although it could be improved by the appointment of physiotherapists and additional dentists if these were available.

8. HEALTH EDUCATION IN SCHOOLS.

Although members of the staff of the Health and Welfare Department have undertaken a considerable amount of health education in connection with persons beyond the age of leaving school (*e.g.*, giving courses of lectures to student nurses and to student teachers of gymnastics) and although—as previously mentioned—both the examinations conducted by the medical officers and the health surveys conducted by the health visitors are important educational experiences for pupils, neither medical officers nor health visitors played any part in the formal health education of school children.

The idea of appointing several full-time mothercraft teachers some years ago may have been devised because of the extreme shortage of health visitors; but, since the persons appointed originally and the person appointed to fill a recent vacancy were health visitors from the Corporation's staff, the effect has been to redesignate certain health visitors as mothercraft teachers, to detach them from practical health visiting and to deprive them of opportunities to study problems of emotional and social health in the homes of the people. It is, of course, possible that there are some advantages in the employment of full-time health teachers, but, without seeking to be dogmatic, the writer would suggest that thought might usefully be directed to the following four questions:—

- (a) What aspects of health education can be best handled by the ordinary class teachers, who, in addition to knowing their pupils well, are in a position to integrate the teaching of health with the teaching of other subjects?

- (b) What aspects of health education can be best tackled by school medical officers and school health visitors, both of whom, as health specialists whose whole professional lives are spent in dealing with health problems, are clearly in a position to make a useful contribution?
- (c) What aspects of health education can be best entrusted to full-time mothercraft teachers?
- (d) What part should members of the School Health Service play in the planning and organisation of school health programmes?

9. PARTICIPATION IN HEALTH CARE AND EDUCATION OF HANDICAPPED CHILDREN.

The Service has functioned adequately, although a physiotherapist is badly needed for Beechwood School.

10. PROVISION OF A HEALTHY ENVIRONMENT.

The School Health Service has done a reasonable job in respect of existing buildings, but its members have seldom been consulted when new buildings were being designed or structural alterations were taking place.

It will be noted that the service has been described as functioning "adequately" only in respect of health assessment, correction of remediable defects, and participation in the care of handicapped children. This is not meant to imply that in respect of the other headings the Aberdeen School Health Service is less advanced than that of comparable cities. The fact is that in the country generally there has been in recent years an undue emphasis on treatment and a lack of stress on prevention: consequently, not only have the health-promoting and disease-preventing services become grossly understaffed, but, even in these services, there has been a tendency to concentrate more on what may be termed "treatment aspects."

The task for the immediate future must be, without in any way neglecting or failing to develop such treatment aspects as correction of remediable defects and care of the handicapped, to raise the standard of the preventive aspects.

GENERAL STATISTICS.

The school population has continued to increase, the numbers on the registers being 453 more than in the previous session and almost 1,500 more than in the session 1952-53. The rise is mainly a result of the high birth-rates of the years 1946-48, and the rate of increase is now slowing down. Details of schools and scholars are given below.

Number of schools—

(a) Primary—Under Education Authority	43
(b) Junior Secondary do. do.	10
(c) Secondary do. do.	3
(d) Nursery do. do.	4
(e) (i) Special Schools do. do.	3
(ii) Special Classes in ordinary schools	—
(iii) Nursery Classes	7
(f) In receipt of grant from Education Committee and under Medical Inspection	2

Number of children on the registers	30,754
Number of children in average attendance	29,086

SANITARY CONDITION OF SCHOOLS.

The school doctors and health visitors continued, during their visits to the schools, to survey buildings, classrooms, cloakrooms, lavatories, &c. Lighting, ventilation, cleanliness of rooms, heating, and condition of lavatories, as well as the availability of drinking water and the nature of washing facilities all came under scrutiny. In addition, inspectors from the Sanitary Section of the Health and Welfare Department visited the schools from time to time.

During the year a number of defects were notified to the Architect's Department. These defects—usually minor defects in sanitary conveniences, drinking fountains, &c.—were, as a rule, swiftly rectified.

On the whole, it is fair to say that the conditions under which children are educated in Aberdeen can be regarded as satisfactory from a health point of view. Heating and lighting are in general good, sanitary conveniences are kept in a satisfactory condition, and the regulations for disinfection and cleansing of schools are adequately implemented.

In recent years, a considerable amount of new building has taken place, and also a considerable amount of reconstruction of older schools. It may be of interest here to record information from the Architect's Department about new work undertaken during the year.

(a) *New Schools—*

Kincorth Primary	. . .	Under construction.
Mastrick Infant	. . .	Do.
Muirfield	. . .	Do.
Northfield Secondary	. . .	Work almost completed.
Kingswood Infant	. . .	Work completed.
Quarryhill Primary	. . .	Do.

(b) *Reconstructions, &c.—*

Middle Secondary	. . .	Work commenced.
Woodside Primary	. . .	Do.

Schools repainted during the year included King Street, Powis Secondary (part), Hilton Secondary (part), Ruthrieston Secondary (part), St. Mary's R.C., Middle Secondary (swimming pond), Hanover Street (part), Middlefield (Infant rooms), Tillydone Primary and Victoria Road Schools.

Repairs to lavatories, &c., were carried out in the following schools:—St. Peter's R.C., Middlefield, Walker Road, Ashley Road; and provision of additional basins and of hot water to wash-hand basins was completed in Skene Square, St. Peter's R.C. and Broomhill Schools.

ORGANISATION AND ADMINISTRATION.

A. SYSTEM AND EXTENT OF MEDICAL INSPECTION AND TREATMENT.

The age-groups designated by the Department of Health for Scotland for obligatory medical examination in 1955-56 were:—entrants (approximately 5 years

of age), pupils born in 1946 (approximately 9 years old), those born in 1942 (approximately 13), and those born in 1939 (approximately 16), as well as pupils born in 1948 (visual acuity and hearing only). These groups were duly examined and, in addition, a rapid and less comprehensive survey was made of school entrants as soon as practicable after their initial entry.

The purpose of these routine medical overhauls is fourfold:—

- (a) the detection of early defects, often at a stage where their existence is still unsuspected by pupils and parents, as well as the identification of more obvious conditions of disease and disability;
- (b) the advising of pupils and parents about the most appropriate measures by which the defects can be rectified;
- (c) the identification of pupils whose educational programmes may need modification; and
- (d) the inculcation of ideas of health maintenance and of active promotion of health. This last function is probably the most important of all, and forms a valuable facet of health education work in schools.

In most cases of diseases or defects requiring medical treatment, the parents are advised to contact their general practitioners. Nevertheless, ample need remains for the various school clinics—*e.g.*, minor ailments clinics; skin diseases clinics; orthopædic clinic; orthoptic clinic; dental clinics; and ear, nose, and throat clinic.

For two years the numbers of children attending the minor ailments clinics and skin diseases clinics have been decreasing. It is perhaps too early to say whether these decreases are due to the success of the disease-preventing services or are simply a matter of coincidence.

B. SYSTEM AND EXTENT OF DENTAL INSPECTION AND TREATMENT.

The report of the Chief Dental Officer is given later.

C. SCHOOL NURSING AND ARRANGEMENTS FOR "FOLLOWING-UP."

The School Nursing Service is provided by the Corporation's health visitors, who are, as far as is practicable, allocated to schools serving their particular districts.

(1) *Attendance at Medical Inspection.*—According to a practice that used to be almost universal and that still remains standard in most areas, the health visitor of the district accompanies the medical officer in school during a medical inspection—the weighing, measuring, and vision-testing of the children having taken place some days previously. It has been claimed in some quarters that to employ a health visitor on such work is to mis-use the time of a very highly trained officer; but the health visitor can often give valuable information to the medical officer about the child's physical and mental progress, background, and home conditions; and the contact with the mother at the time of medical inspection is helpful to the health visitor in her work with the child and the family.

(2) *Health Surveys by Health Visitors in Schools.*—Health inspections (which are perhaps the most important part of the whole school health service) have been carried out in all primary, junior secondary, and special schools at least once every three months during the school session. The ideal is, of course, for the health visitor to see every child not less than once each term, but continuing shortage of staff still renders this ideal impracticable; an attempt is made to inspect each child twice annually.

During these health surveys, many children who are not making reasonable educational or physical progress, or who show signs of early disease, or who present deviations from normality in respect of growth or development or behaviour, are picked out, given any necessary advice, and, where needful, referred to the school medical officers or to general practitioners. At these inspections, children found to be malnourished, showing signs of excessive fatigue, nervous, dirty, inadequately clad, malodorous, or suffering from pediculosis are particularly noted, and the homes are visited where the health visitor deems this course desirable.

In the course of these health inspections a great deal of informal instruction on the promotion of health and on personal hygiene is given to individual children and to small groups as the need and the opportunity arises. Although much of the home visiting done by the health visitors has in the past been for cases of neglect and dirty conditions, and although due attention must still be devoted to these matters, there is nowadays an increasing concentration upon physical defects and behaviour problems.

(3) *Follow-up and Home Visiting.*—Much work of high value is carried out by the health visitors in the following-up of children found to require observation or treatment. This work entails numerous visits to schools and necessitates quite a lot of clerical work by the health visitors to maintain adequate records. In many cases home visits are paid as an essential part of the follow-up, to ascertain whether the treatment recommended for the child is being carried out, or to explain and interpret to parents the need for further examination or further treatment. Visits are also undertaken to obtain any necessary information about a child's home circumstances.

An important duty devolving upon the school health visitor is that of acting as a link between the home and the school. If she is to discharge that duty adequately, a sufficient number of home visits is essential; but the frequency of visits is, of course, governed by the degree of adequacy or inadequacy of the staff.

The male inspector attached to the school health service also carries out home visitation when it is required in connection with arrangement for treatment of scabies and verminous cases, failure to provide spectacles, or other prescribed treatment, and investigation of family circumstances for various reasons.

D. CO-ORDINATION WITH THE PUBLIC HEALTH SERVICE AND WITH OTHER DEPARTMENTS OF THE AUTHORITY WHICH RENDERS SERVICES TO CHILDREN.

In Aberdeen, complete co-operation with the other portions of the public health service is ensured by the fact that the School Health Section is part of the

Health and Welfare Department. As has already been indicated, the health visitors act as school nurses, and four of the departmental medical officers undertake work partly in the maternity and child welfare field and partly in the field of school health. Other medical officers still work full time on school health work, but in all cases there is a very close liaison. For instance, appropriate cases are referred to the School Eye Clinic or to the Dental Clinics by the Maternity and Child Welfare Section, and the entire resources of the Health and Welfare Department are available at need. Cases of chest conditions or suspected chest conditions are referred for investigation to the Chest Clinic under the auspices of the Regional Hospital Board. As for the control of infectious diseases, information about the incidence of the non-notifiable inspections (such as measles, rubella, and chickenpox) often reaches the Health and Welfare Department through the School Welfare (formerly Attendance) Department, and the statutory certificates of exclusion from school on account of infectious diseases were transmitted to the head teachers through that department until January, 1956.

Visits are paid by medical officers to the remand home (which is under the control of the Children's Department) for the purpose of examining children (usually delinquents) on entry to the home, and also for the statutory examinations, both physical and mental, of children about to be admitted to approved schools. Children admitted to the Reception Centre (under the Children's Department) also receive medical examination, as do children who are referred for investigation at the Child Guidance Clinic.

E. CO-OPERATION WITH VOLUNTARY BODIES AND OTHER OUTSIDE AGENCIES.

There is good two-way co-operation between the department and certain voluntary bodies which provide services for children. Although, as has been noted above, children in need of medical or surgical treatment are, in the first instance, usually referred to the family doctor, certain types of case are—by a long-standing arrangement satisfactory to all parties—referred directly to Aberdeen Royal Infirmary or to the Royal Aberdeen Hospital for Sick Children. There is, for example, a standing arrangement with the Dermatological Out-patient Departments of these institutions to treat children suffering from ringworm (particularly those who are deemed likely to require x-ray treatment), verrucosis, &c. Similarly, the Eye Institution deals with cases of epidemic conjunctivitis occurring in school children. The Cleansing Station at the City Hospital, under the control of the Special Hospitals Management Committee, continues to deal with cases of scabies and dirty and verminous conditions occurring in school children and their families, the family being treated as a unit wherever possible.

Again, there is a long-standing arrangement with the Committee of Linn Moor Convalescent Home, Culter, by which school children suffering from pre-tuberculous conditions, debilitated, malnourished, or convalescent from illness, are given a period in the Home, the duration varying according to the circumstances of the individual case.

Any children who (*e.g.*, by reason of the mother's removal to hospital) are to be temporarily cared for in the Children's Shelter (controlled by the Aberdeen Association of Social Service) are inspected by school medical officers before

admission, to minimise the possibilities of infectious or contagious disease occurring in the Shelter.

Towards the middle of the school year, the Town Council granted the request of the Regional Hospital Board's Blood Transfusion Unit that the Health and Welfare Department should co-operate with Dr. T. M. Allan, of the Blood Transfusion Service, in research into the distribution of the different blood-groups in the community. As far as school children are concerned, the request was that, in all cases in which parental consent was given, 5-6 drops of blood from each school child undergoing routine medical inspection should be withdrawn by the medical officer pricking a finger with a hypodermic needle. The blood-samples were then to be conveyed to the blood transfusion unit, where the individual child's blood-group was to be determined.

The co-operation of the Education Department, with respect both to facilities and to provision of transport, was readily secured, and the following circular was issued to parents of the children involved by Head Teachers:—

“Dear Sir or Madam,

DETERMINATION OF YOUR CHILD'S BLOOD-GROUP.”

In a case of serious accident or injury, previous knowledge of a person's blood-group can save valuable time and may sometimes make the difference between life and death. There is also some evidence that a person's blood-group may play some part in deciding to which diseases that person is liable. From many points of view, therefore, it is useful for a child's blood-group to be known to him and, in the case of a young child, to his parents.

Determination of a person's blood-group is a fairly simple matter which, from the point of view of the individual, involves nothing more serious than a tiny prick of a finger with a needle.

For the immediate future, Aberdeen children are being offered determination of their blood-group. If you wish to take advantage of this service, please complete the attached slip and return it to the child's school before the school medical inspection.

If you give your consent, the pin-prick will be administered by a medical officer from the Health and Welfare Department of the Corporation, the blood will be examined by Dr. T. M. Allan, of the Blood Transfusion Service, and the blood-group will subsequently be notified to you.

If you do not wish to take advantage of the service, please indicate on the slip that you are refusing your consent.

Yours sincerely,

I. A. G. MACQUEEN,

Medical Officer of Health and School Medical Officer.

Please tear off here.

CHILD'S NAME.....

DATE OF BIRTH..... SCHOOL.....

* (1) I consent to the blood-group of the above-mentioned child being determined and authorise a medical officer of the Health and Welfare Department to take the necessary tiny sample of blood from the finger.

* (2) I do not wish my child's blood-group to be determined at present.

(Date).....

*Please delete, as required. (Signature).....”

For obvious reasons, the five-year-olds were at first excluded from the scheme. The percentage of consents from parents was 94·9 per cent. and 673 school children (mainly 13-year-olds and 16-year-olds) were dealt with in the course of routine medical inspection. The procedure (including necessary clerical work and questioning of parents on certain extra matters) slightly slowed up medical inspection, and at the end of the year an attempt was being made to secure that the Blood Transfusion Service would undertake some of the work directly.

The School Health Service also co-operates, where appropriate, with the Royal Scottish and the Aberdeen City and County Societies for the Prevention of Cruelty to Children.

National Survey of the Health and Development of Children.—As was reported last year, an enquiry into the growth, health, and development of children is being carried out by the Joint Committee of the Institute of Public Health (University of London), the Society of Medical Officers of Health, and the Population Investigation Committee. Through the Maternity and Child Welfare Services, some 6,000 children born in England, Wales, and Scotland between 3rd and 9th March, 1946, have been carefully followed up during the early years of their lives and a unique amount of information has been collected about their home conditions, their illnesses, accidents, growth, and development. The children are drawn from all social classes, and it is hoped that their experiences will provide an unbiased picture of the health and social environment of children in Great Britain. These children now attend school and the investigation is being continued during their school lives. During the past year medical examination of the children has not been required but the school health visitors paid a home visit to each child and obtained certain additional information required for the enquiry. Records of absences from school are kept by the head teachers, and the health visitors are responsible for recording any illnesses which occur during vacations. Medical examination of the children concerned has been asked for in January, 1957. Aberdeen's quota of the children concerned is 14.

F. CO-OPERATION WITH TEACHERS AND PARENTS.

Co-operation with parents and teachers is, of course, essential in the interests of the children.

It is pleasant to be able to report that, in general, the relations between the school doctors and health visitors on the one hand and the teaching staff on the other are good and mutually helpful. The vast majority of teachers are very ready to co-operate in measures taken for improving the health of the children under their care. In some schools, the school medical officers and health visitors are frequently consulted by the teachers on aspects of the health education curriculum as well as on other matters. Nevertheless, there is need for more and better co-operation in the future. It is of the highest importance that every teacher should appreciate that the school health visitor is—like the school doctor—a very highly trained professional officer, and that the expert guidance of both these officers is constantly available

to them, not only on matters of physical health but also—and equally—on matters of mental health.

The attendance of parents at routine medical inspections is pleasingly high, although it naturally varies according to the age-group being examined. At the inspection of five-year-old children, 95.9 per cent. of the children had a parent present; at the inspection of the nine-year-olds, the percentage was 90.3; it was 62.2 at the inspection of thirteen-year-olds; and it was 28.8 at the inspection of sixteen-year-olds; giving an over-all percentage of 82.0—a figure almost identical with that of 82.4 in the previous year. Medical inspection is now completely accepted by parents as part of the school routine. Parents of children in the older age-groups are generally content to allow their children to come unaccompanied unless there is some known or suspected condition about which they wish advice. The attendance of 24 parents for every 25 school entrants and of 9 parents for every 10 children aged nine years is highly gratifying. At these inspections advantage is taken by both doctor and health visitor of the attendance of the parents to instil principles of health maintenance in both parent and child and to inculcate the idea that promotion of health is part of one's duty both to oneself and to the community. As previously mentioned, this is a highly important part of the school medical inspections.

Talks are occasionally given by the school doctors and health visitors to meetings of Parent-Teacher Associations connected with some of the schools. The usefulness of these talks is undoubtedly limited by the fact that the parents to whom one most desires to talk are not present; but such talks, nevertheless, play a not inconsiderable part in spreading knowledge of the principles of healthy living and thereby improve the health of the citizens, young and old alike.

THE FINDINGS OF MEDICAL INSPECTION.

General.

As mentioned above, systematic medical inspection was carried out in the four age-groups prescribed—(1) entrants (usually 5-6 years), (2) children aged 9 years, (3) children aged 13 years, and (4) children aged 16 years. As it has hitherto not been deemed practicable, without undue expenditure of time, to examine the vision of children entering school for the first time, vision- and hearing-testing was carried out in the case of the 7-year-old children. A new departure during the school year was the audiometric testing by the audiometrician of the hearing of 5-year-old children, with surprisingly good results, as related under the heading of "Audiometric Examination" further on. In addition, a superficial inspection of 5-year-old children was carried out as soon as possible after their entry to school.

Four hundred and seventy-five visits were paid to schools by the medical officers in connection with systematic medical inspection (a figure which may be compared with 451 visits in the previous year), and before each inspection a good deal of preparatory work was done by the health visitors—*e.g.*, the weighing, measuring, sight-testing, and hearing-testing of the children,

Preliminary Inspection of "Entrants."

The preliminary rapid review of all school entrants for detection of obvious physical defects and verminous conditions revealed the following details:—

Total number inspected	2,518
Dirty heads—Nits	40 or 1·6 per cent.
Vermin	1 or 0·04 per cent.
Squints	107 or 4·2 per cent.
Other diseases	81 or 3·2 per cent.
Number excluded for various infections	4 or 0·2 per cent.
Unsatisfactory clothing	—

Most of these proportions are slightly lower than in the previous year.

Systematic Medical Examination.

The routine medical overhauls provide valuable information about the frequency of common defects. The number of children examined was 803 more than in the previous year.

A study of the results of these examinations over a series of years shows that the percentage of children free from defects has risen steadily: 31·9 per cent. in 1951-52, 36·4 per cent. in 1952-53, 38·4 per cent. in 1953-54, 42·7 per cent. in 1954-55, and now 45·3 per cent. in 1955-56. Again, the proportion free from defects other than those of vision or teeth has risen steadily: 43·3 per cent. in 1951-52, 47·1 per cent. in 1952-53, 51·5 per cent. in 1953-54, 58·4 per cent. in 1954-55, and 61·6 per cent. in 1955-56. These are heartening figures, and would be more heartening did not an analysis of children with serious or persisting defects reveal that these are on the increase: in 1954-55 8·8 per cent. of all children examined (including 11·0 per cent. of school entrants) had such defects, whereas, in 1955-56, 9·4 per cent. of all children examined (including 12·6 per cent. of school entrants) fell into this category—a fact which may well be associated with shortage of disease-preventing staff.

Details of the number and percentage of children in each age-group found to be suffering from particular defects are given in Table II at the end of this section of the Report. A summary is presented here.

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.	Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	8,637	6	·1	9. Ears—			
2. Footgear unsatisfactory . . . . .	..	4	·04	(a) Diseases:			
3. Cleanliness—				Otorrhœa	8,637	28	·3
(a) Head: Nits . . . . .	..	16	·2	Other diseases . . . . .	..	161	1·9
Vermin . . . . .	..	4	·04	(b) Defective hearing:			
(b) Body: Dirty . . . . .	..	—	—	Grade I	5,802	17	·3
Vermin . . . . .	..	—	—	Grade IIa . . . . .	..	10	·2
4. Skin—				Grade IIb . . . . .	..	—	—
(a) Head: Ringworm . . . . .	..	—	—	Grade III . . . . .	..	—	—
Impetigo . . . . .	..	26	·3	10. Speech—			
Other diseases . . . . .	..	67	·8	Defective articulation	8,637	82	·9
(b) Body: Ringworm . . . . .	..	—	—	Stammering . . . . .	..	15	·2
Impetigo . . . . .	..	5	·1	11. Mental and Nervous Condi-			
Scabies . . . . .	..	1	·01	tion—			
Other diseases . . . . .	..	204	2·4	(a) Backward . . . . .	..	8	·1
5. Nutritional State—				(b) Dull . . . . .	..	—	—
Slightly defective . . . . .	..	167	1·9	(c) Mentally deficient (educable)	..	—	—
Bad . . . . .	..	6	·1	(d) Do. (ineducable) . . . . .	..	—	—
6. Mouth and teeth unhealthy . . . . .	..	378	4·4	(e) Highly nervous or unstable	..	92	1·1
7. Naso-pharynx—				(f) Difficult in behaviour . . . . .	..	33	·4
(a) Nose:				12. Circulatory System—			
(i) Obstruction requiring				(a) Organic heart disease:			
observation . . . . .	..	473	5·5	(i) Congenital . . . . .	..	16	·2
(ii) Obstruction requiring				(ii) Acquired . . . . .	..	21	·2
operative treatment . . . . .	..	17	·2	(b) Functional conditions . . . . .	..	17	·2
(iii) Other conditions . . . . .	..	7	·1	13. Lungs—			
(b) Throat:				Chronic bronchitis . . . . .	..	33	·4
(i) Tonsils requiring obser-				Suspected tuberculosis . . . . .	..	52	·6
vation . . . . .	..	864	10·0	Other diseases . . . . .	..	185	2·1
(ii) Tonsils requiring oper-				14. Deformities—			
ative treatment . . . . .	..	79	·9	(a) Congenital . . . . .	..	55	·6
(c) Glands:				(b) Acquired (infantile para-			
(i) Requiring observation . . . . .	..	313	3·6	lysis) . . . . .	..	30	·3
(ii) Requiring operative				(c) Acquired (probably rickets)	..	124	1·4
treatment . . . . .	..	—	—	(d) Acquired (other causes) . . . . .	..	225	2·6
8. Eyes—				15. Infectious disease . . . . .	..	4	·04
(a) External diseases:				16. Other diseases or defects . . . . .	..	1,041	12·1
Blepharitis . . . . .	..	122	1·4	17. Classification:			
Conjunctivitis . . . . .	..	4	·04	Group I . . . . .	..	3,909	45·3
Corneal opacities . . . . .	..	3	·03	Group IIa	5,802	765	13·2
Strabismus . . . . .	..	350	4·1	Group IIb	8,637	115	1·3
Other diseases . . . . .	..	47	·5	Group IIc	5,802	6	·1
(b) Visual acuity with/without				Group III	8,637	3,034	35·1
glasses:				Group IVa . . . . .	..	570	6·6
Fair	5,802	933	16·1	Group IVb . . . . .	..	238	2·8
Bad . . . . .	..	261	4·5	Number notified to parents as			
Recommended for refrac-				suffering from defects . . . . .	..	632	7·3
tion . . . . .	..	410	7·1	Number under observation . . . . .	..	3,582	41·5
				Number of parents present at			
				inspection (7,056) . . . . .	..	—	82·0
				Number wearing glasses . . . . .	..	706	8·2

Although most of these figures show only the usual slight differences from year to year, it is highly satisfactory to note that the number of children with dirty heads and bodies has decreased to the lowest figure ever recorded (a total of 20 or less than one-quarter of one per cent. of all children examined) and that the number of school children classified in Group I (*i.e.*, free from defect) at 45.3 per cent. is the highest figure yet recorded, while the percentage showing sub-normal nutrition remains constant at 2.0.

It is less satisfactory to have to record that the figures for unhealthiness of mouth and teeth have shown a steady increase yearly for the last few years (in 1952-53, 3.4 per cent.; in 1953-54, 3.6 per cent.; in 1954-55, 4.0 per cent.; and in 1955-56, 4.4 per cent.).

The changes in the other headings show no evidence of deterioration in general health in the school population as a whole.

The percentage of children formally notified to parents as suffering from defects (7.3) is fairly similar to that of last year as is also the percentage of children requiring to be kept under observation by the doctors and nurses. The proportion of parents present at medical examination, at 82 per cent., is slightly lower than that of the record year 1953-54, when the figure was 83.1 per cent.

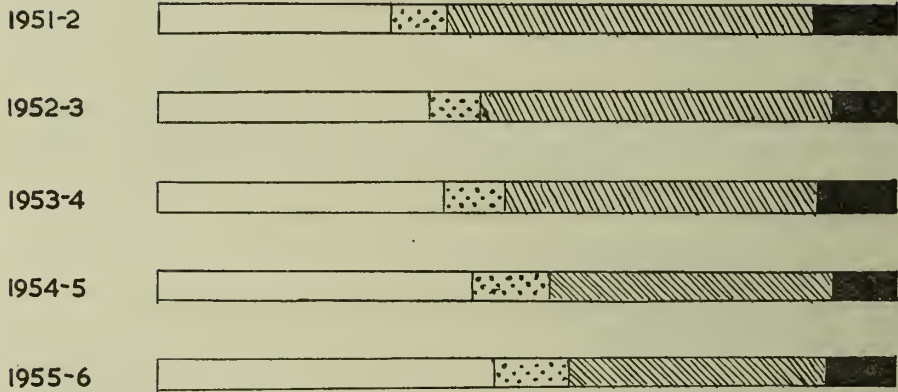
Classification on routine examination.

Figures for 1955-56 and percentages for the last five years are given below in tabular form and then in pictorial form.

Classification.	1955-56.		1954-55.	1953-54.	1952-53.	1951-52.
	No.	%	%	%	%	%
I. Free from defects . . .	3,909	45.3	42.7	38.4	36.4	31.9
*IIA. Defective vision but otherwise free from defects . . .	765	14.9	14.0	11.4	9.4	10.0
IIB. Mouth and teeth unhealthy but otherwise free from defects .	115	1.3	1.6	1.5	1.1	1.2
*IIc. Combination of IIA and IIB .	6	0.1	0.1	0.2	0.2	0.2
III. Children with ailments from which recovery is expected in a few weeks . . .	3,034	35.1	38.1	42.7	48.1	49.7
IV. Children with more serious defects—						
(a) Where cure is considered possible . . .	570	6.6	6.2	7.6	6.5	8.1
(b) Where only improvement is considered possible . . .	238	2.8	2.6	2.7	2.1	3.1

* Percentage with eye defects refers to children receiving visual tests, *i.e.*, a different total from number having routine medical overhauls. Hence the percentage when added will not come to exactly 100.

CLASSIFICATION BY ROUTINE EXAMINATION



□ GROUP I - FREE FROM DEFECTS

▤ GROUP II - DEFECTS OF MOUTH AND/OR VISION ONLY

▨ GROUP III - TRIVIAL AILMENTS

■ GROUP IV - SEVERE DEFECTS

HEIGHTS AND WEIGHTS OF CHILDREN EXAMINED.

The following table gives particulars of the heights and weights of children examined. The small figure in the age column refers to months: thus 5³ means 5 years 3 months.

Age Group (years).	BOYS				GIRLS			
	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,076	5 ³	42·5	42·2	989	5 ³	42·1	40·7
9—10	1,587	9 ⁴	51·7	64·3	1,413	9 ⁴	51·3	62·6
13—14	1,225	13 ⁶	59·5	94·4	1,159	13 ⁶	59·9	99·4
16—17	202	16 ⁶	67·8	134·4	160	16 ⁶	63·8	126·6

For comparison with previous years, reference should be made to Table V at the end of the report.

RE-INSPECTION.

Re-inspection includes the re-examination of children who have had some defect or defects discovered at routine medical examinations during the year and for whom treatment had been advised; it also includes certain children who were placed under observation because it was suspected that they might be suffering from some ailment.

The total number of children re-inspected was 6,916, as compared with 6,123 last year, with 5,410 in 1953-54, and with 2,643 in 1952-53. The rising figures denote better follow-up, not more illnesses. Details of re-inspection are as follows:—

	Number Re-examined.	Treatment Completed.	2nd Notice.	Number Improved but kept under Observation.
Dirty Heads	102	30	41	31
Defective vision	886	461	156	269
Enlarged tonsils	314	124	100	90
Skin diseases	34	20	12	2
Scabies	3	2	1	—
Other diseases	215	67	126	22
Number under observation .	6,767	3,383	3	3,381
Total	8,321	4,087	439	3,795

It will be observed that it is stated that 6,916 represents the total number of children re-inspected, whereas in the table the number is given as 8,321. The difference is due to the fact that some of the children examined had more than one defect.

For two terms in four schools a regular monthly visit was paid by the School Medical Officer and Health Visitor in addition to visits for routine medical examinations. In advance, the teaching staff had selected pupils for examination who,

from observations in school, had appeared to be in need of advice or treatment. The observations of teachers are valuable, and further advice has thus been given to cases requiring improved general care, to those suspected of orthopædic defects and defects of hearing and vision, as well as to those showing irregularities of behaviour. The numbers of those seen have been included in the general figures for re-inspection.

OTHER EXAMINATIONS.

(1) *Visits by School Medical Officers.*

These are visits for the supervision of hygienic conditions, the investigation of outbreaks of infectious disease, the study of various influences affecting the physical and mental well-being of the children, and the examination of mentally handicapped children. During the year, 241 such visits were paid by the medical officers (as compared with 238 in 1954-55, 231 in 1953-54, and 162 in 1952-53).

(2) *Unannounced Visits by Health Visitors.*

Ideally, the health visitors should inspect every child each term (with the possible exception of children who are receiving a routine medical overhaul during that term) and selected children at more frequent intervals. As in previous years, the available staff was insufficient for this purpose, but practically every child was inspected at least once during the year. It is of supreme importance that the number of these visits should be increased whenever staff permits.

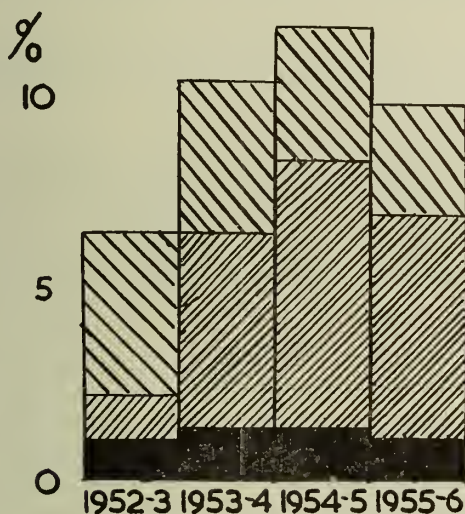
Since the number of health inspections was small in the past, an excessive prominence may then have been given to "cleanliness," which, of course, must never be neglected. Nowadays, however, even greater emphasis is placed by the health visitors on such points as nervousness, nutrition, fatigue, posture, debility, &c., but (to allow comparisons with past years) all these are grouped here under the heading of "other diseases":—

Total number of ordinary inspections	54,118
<hr/>	
Total number of inspections showing live vermin of head	114
" " " " " nits in hair	1,401
" " " " " impetigo	71
" " " " " scabies	4
" " " " " other diseases	3,161
" " " " " unsatisfactory clothing	338
" " " " " unsatisfactory footwear	202

In addition, the health visitors examined 11,081 "selected" cases, many of whom had previously been found to have some defect of cleanliness. Of these, 144 (or 1.3 per cent.) were found to have live head vermin, and 1,565 (or 14.1 per cent.) to have nits of the hair.

It is interesting to compare the health visitors' findings at ordinary inspections over several years. The number of inspections showing vermin, nits, scabies, or impetigo fell below 2,000 for the first time in 1954-55, and has now fallen below 1,600. The number showing unsatisfactory clothing or footgear fell below 700 for the first time in 1954-55, and is now 540. On the other hand, the number of inspections revealing "other diseases" was only 570 in 1952-53; in 1953-54 it soared to 2,873 (or more than one-half of all the abnormal findings), and since then it rose to 3,704 in 1954-55, and then fell slightly to 3,161 in 1955-56. The following diagram expresses these findings as percentages of all ordinary inspections:—

PERCENTAGES OF TOTAL NUMBER OF ORDINARY INSPECTIONS IN RECENT YEARS



▨ VERMIN, NITS, SCABIES, IMPETIGO.

▨ OTHER DISEASES

■ UNSATISFACTORY CLOTHING & FOOTGEAR

(3) *Home Visits by Health Visitors.*

These visits are among the most important aspects of the school health service, and enable the visiting nurse to act as a link between home and school, to the benefit of both. Unfortunately, the visits are also time-consuming, and shortage of staff prevented an adequate number of visits being paid.

Health visitors paid 2,377 visits to homes to give advice about school children (as compared with 2,053 visits in the previous year). The total number of children involved was 2,736. During the year, the classification of the visits of the health visitors was divided into "visits for medical reasons" and "visits for reasons of defective cleanliness in some form," with the following results, comparable figures for 1954-55 being given in brackets:—

Medical.		Cleanliness.	
1st visits.	Re-visits.	1st visits.	Re-visits.
1,280 (903)	647 (476)	355 (379)	443 (542)

As a result of their visits, the health visitors reported 229 children as being "slightly improved," 98 as "markedly improved," and 19 as "cured."

(4) *Examination of vision of seven-year-old children.*

During the year, 2,475 children born in 1948 had their vision tested, and 220 were referred to the school eye clinic for refractions.

(5) *Examination for Tertowie Residential School.*

During the year, 377 pupils (173 boys and 204 girls) from secondary schools were inspected before departure for a three weeks' period at Tertowie Residential School. Because of the length of time away from Aberdeen, a very strict standard of examination was required, but only four pupils had to be excluded as unfit.

(6) *Special Educational Treatment.*

(a) *Day Special School.*—After examination, 53 children were recommended for admission to a day special school as mentally handicapped pupils, 5 as physically handicapped pupils, 9 as occupational centre pupils, and 5 pupils were found to suffer from Grade III congenital deafness and were recommended for admission to a day special school for the deaf at the age of 3 years. One of these children, along with his mother, had a prior period in the residential hostel at Ealing, where mothers are trained in the handling of deaf children.

(b) *Residential Special School.*—Five pupils were recommended for admission to the Royal Blind School. Two of these suffered from retrolental-fibroplasia.

(c) *Home Tuition.*—Seventy-eight children have been off school because of illness lasting three months or over. Six of these have never attended school because of gross physical disability; four of the six are unlikely ever to do so. The illnesses causing this loss of schooling are as follows:—tuberculosis, 27; orthopaedic conditions, 17; rheumatic infections, 16; general medical conditions, 11; congenital malformations, 7. Home tuition was recommended in 30 cases. For 2 permanently home-bound girls now aged 14 years and over, typewriting lessons have been

arranged in addition to general tuition in one case and dressmaking lessons in the other. The typewriter and electric sewing-machine have been supplied by voluntary associations. On leaving Beechwood School, a disabled chair-bound pupil has been admitted to Anton House for a period of training in some employment which can subsequently be followed at home.

(d) *Child Guidance*.—The number of cases examined prior to attendance at Child Guidance Centre is 56 (33 boys and 23 girls).

Referrals from schools	52
Referrals from School Medical Officers	4
Reasons for referral—	
Backwardness—general and specific	16
Behaviour disorder	33
Enuresis (only reason given)	5
Speech	2

Age-groups of referrals—

5-10 years—Boys, 23; girls, 12; total—35.

10-15 years—Boys, 11; girls, 10; total—21.

(e) *Pre-school Examinations*.—In addition, 27 pre-school children were examined for possible mental or physical disability.

(f) *School Examinations*.—There are 6 children of school age who, because of mental handicap, are still unfit for any form of education and at present remain at home. It is likely that all 6 children will be capable of entering the occupational centre at a later date.

(g) *Ineducables*.—Three pupils were reported as ineducable. Twelve pupils, on reaching school-leaving age, were reported to the local health authority as requiring to be dealt with under the Mental Deficiency Act—11 from Rubislaw Occupation Centre and 1 from Polmuir Road School.

(7) *Audiometric Examination of seven-year-old and other Children.*

Systematic audiometric testing for the early and scientific detection of hearing defects (commenced in 1953) was continued during the year under review. The children tested were those born in the years 1950, 1948, and 1944, and also children of other ages who were suspected of having some degree of deafness by the teachers or health visitors. The method used was again the "sweep" method at 15 decibels of hearing loss by use of the pure-tone audiometer.

The classification of those found to have a hearing loss was the same as was described in the report for 1953-54, and the cases of apparent defective hearing were followed up medically (including the use of the auriscope). In cases where there was no obvious temporary cause, or where it was thought that a hearing aid might be necessary, the children were referred to the Ear, Nose, and Throat Department of the Royal Aberdeen Hospital for Sick Children.

Deafness is normally classified into four grades: Grade I—slightly hard of hearing; Grade IIA—requiring favourable position in class and may need a hearing-aid; Grade IIB—often needing to be taught in a special class by special methods; and Grade III—requiring to be taught in a school for the deaf.

The results of the work done during the year are as follows:—

	Number Tested.	Normal.	Defective.
Group I—			
All children born in 1950 . . .	2,446	2,305	141
" " " " 1948 . . .	2,907	2,811	96
" " " " 1944 . . .	2,048	1,958	90
Group II—			
Children of other ages suspected of deafness	576	472	104

CLASSIFICATION OF CHILDREN WITH DEFECTIVE HEARING.

	DEAF IN ONE EAR.		BOTH EARS AFFECTED.				
	Normal/1	Normal/2A	1	1/2A	2A	2B	3
GROUP I—							
Born 1950	99	3	35	1	3	—	—
" 1948	71	5	20	—	—	—	—
" 1944	59	15	12	—	4	—	—
GROUP II—							
Other ages	59	8	30	1	6	—	—

NUMBER OF CHILDREN REFERRED FOR INVESTIGATION AND/OR TREATMENT AFTER EXAMINATION BY SCHOOL MEDICAL OFFICERS.

	Group I			Group II
	1950.	1948.	1944.	Other Ages.
Number referred to Hospital for Sick Children . . .	6	6	2	7
Number referred to School Ear, Nose and Throat Clinic	13	12	2	15
Number referred to own doctor	18	12	8	25
Number where no action was necessary	65	66	47	40
Number absent	4	—	—	2
Number awaiting examination by school medical officers .	36	—	30	27

In addition to the above, 39 children entering the Special Schools for the first time were tested. Of these, four were found to be defective in one ear only. The others were found to have normal hearing, and appropriate action was taken in the cases of the defective hearing.

(8) *Leavers.*

Individual reports on 41 children leaving special schools were submitted to the Youth Employment Officers, and a case conference was held on each. As already mentioned, twelve children leaving the special schools were reported for the purposes of the Mental Deficiency Acts under Section 57. Seven of these were considered suitable for admission to an adult day occupational centre if such were available and were recommended for admission to the present centre for under 16's meantime.

MEDICAL TREATMENT.

A—MINOR AILMENTS, SKIN DISEASES, &c.

(1) *Cuts, Bruises, Sprains, Minor Injuries, &c.*

Cases occurring in schools while any of the medical or nursing staff are in the school are dealt with by them, but many cases are given first-aid treatment by the teaching staff, many of whom have had first-aid training. Children requiring further treatment are referred to their own doctor or, in serious cases (*e.g.*, fractures), to the casualty departments of the general hospitals. No information is at present available about the number of children in this group who have received treatment by their own medical attendant or at any of the hospitals.

(2) *Attendance (Minor Ailments) Clinics.*

These clinics were held at Powis Secondary School on Thursdays at 9.30 a.m. and at Charlotte Street Clinic, 46, Charlotte Street, on Mondays and Thursdays at 2 p.m. (the latter instead of, as previously, at Child Welfare Centre, Castlegate, and Dispensary Buildings, Guestrow). Children are referred from various sources, such as health visitors, school welfare officers, and head teachers. During the year, 1,237 children were referred, and made 1,436 attendances: both figures represent a slight decrease from those for the previous year.

(3) *Diseases of the Ear, Nose, and Throat.*

The Ear, Nose, and Throat Clinic is now held at Charlotte Street Clinic, 46, Charlotte Street, on alternate Fridays at 2 p.m. A health visitor is in attendance daily at 4 p.m. to give treatment where necessary. The attendances during the school year 1955-56 were as follows:—

Number of new cases	58
Number referred to hospital	12
Number referred to own doctor	13
Number treated at clinic	13
Number discharged requiring no treatment	20
Total attendance at clinic	568
Number discharged cured	38

At least 85 per cent. of the new cases are cases of diseases of the ear alone.

The vast majority of cases of enlarged tonsils and adenoids are not referred to the Ear, Nose, and Throat Clinic, but are referred to the family doctor in the first instance.

(4) *Diseases of the Eye, excluding Defective Vision.*

Cases continue to be referred, by arrangement, to the Eye Institution, 142, King Street, Aberdeen. The number of cases so referred was 12 of acute conjunctivitis and 102 of mild conjunctivitis, 10 of severe blepharitis, and 20 of mild blepharitis.

(5) *Diseases of the Skin.*

No cases of ringworm, either of the scalp or body, were found. This compares with one case of ringworm of the scalp and 3 cases of ringworm of the body last year. As far as is known, this happy condition of affairs has not been known before. The usual arrangement for treatment at the Skin Out-Patient Department, Aberdeen Royal Infirmary, Woolmanhill, did not require to be used.

As for impetigo, 145 children were treated at the School Skin Clinic, Dispensary Buildings, Guestrow, Aberdeen; 1,204 attendances were involved. (The figures for the previous year were 216 children and 1,635 attendances, and for 1953-54 were 234 children and 2,059 attendances.) These figures show that, since autumn, 1953, there has been some increase in the prevalence of impetigo contagiosa, the figures for which had been low for some years preceding that year. It is possible now that the bacteria which cause this disease are again becoming rather less virulent.

With regard to scabies, cases are usually referred for treatment to the Cleansing Station at the City Hospital, along with all contacts, adults as well as children. Fifteen families, of whom one or more school-child members of the family were found to be suffering from scabies were so dealt with, involving a total of 5 adults, 30 school children, and 1 child under school age. These figures show a slight increase on the figures for last year, which, it will be remembered, were the lowest for this particular disease ever recorded in Aberdeen.

The number of children known to the department to have been treated for the undernoted skin ailments at the Skin Out-Patient Departments of the hospitals were as follows:—

Acne	5	Naevus	1
Angioma	1	Warts	83

B—DEFECTIVE VISION AND SQUINT.

As a result of vision-testing in schools, 2,279 children (1,078 boys and 1,201 girls) were examined by eye specialists employed by the North-Eastern Regional Hospital Board. The eye clinic was held at Dispensary Buildings, Guestrow, on Mondays, Wednesdays, Thursdays, and Fridays at 2 p.m. Spectacles were prescribed in all necessary cases.

In addition to the 2,279 children mentioned above, 99 pre-school children were also examined at the clinic. These figures compare with 2,701 school children and 130 pre-school children in the previous year.

Treatment of Squint—Orthoptic Department.

The Orthoptic Clinic, in connection with the School Health Service, which started in May, 1955, has continued its work during the year. The purposes and “modus operandi” of the clinic were fully explained in last year’s report. The Orthoptic Clinic has now become more formally established, and the number of children attending continues to increase. The results of treatment are likely to be more satisfactory in the future when it is more realised that the earlier the treatment of squint the better.

Attendances.—The figures for the Orthoptic Clinic are as follows:—Total number of cases seen, 2,637, of whom 461 were new cases and 2,176 were return cases. Of the 461 new cases, 245 were suitable for treatment, 127 were unsuitable, and 89 had no defect. For “cosmetic” reasons, 87 children underwent operations; 7 of them had two operations and 3 had three operations before being considered satisfactory; and, for functional results, 19 children underwent operations, 6 of them having two operations.

C—NOSE AND THROAT (OPERATIVE TREATMENT).

Cases which appear to require operative treatment are, in general, referred in the first instance to the family doctor.

D—ORTHOPÆDIC AND POSTURAL DEFECTS (SPECIALIST TREATMENT).

The Orthopædic Clinic, controlled by the North-Eastern Regional Hospital Board, has, since October, 1952, been held at Dunfermline College of Physical Education, Old Infirmary Buildings, Woolmanhill. This change was made at the suggestion of the authorities of the College of Physical Education, and continues to be mutually helpful to both parties in as much as the schools were finding it increasingly difficult to carry out special remedial exercises for postural defects, &c., and the College is assured of suitable cases for demonstration and teaching purposes. The clinics are held during the session at intervals of approximately one month, according to the number of cases to be examined, and are still conducted by one of the orthopædic surgeons of Aberdeen Royal Infirmary.

During the year, 63 children were examined by the orthopædic surgeons, and 8 of these were referred to one or other of the general hospitals for further investigation and treatment in hospital; special remedial exercises were recommended for 24; and no action, further than the slight raising of soles and heels of shoes in some cases, was considered necessary in the case of 31 children.

In addition to the above-mentioned cases, 143 children who had previously been attended at the clinic paid re-visits for ascertainment of the progress of the prescribed treatment.

E—SPEECH DEFECTS.

The School Health Service continued to co-operate with the Speech Therapy Department in referring appropriate cases to that department. Patients treated during the year included 67 from special schools, 670 from ordinary schools, and 10 from the Child Guidance Centre.

DENTAL INSPECTION AND TREATMENT.

Mr. Hay, Chief Dental Officer, reports as follows:—

Clinics.

The Northfield clinic opened in June, and treatment was begun here just at the end of the school year. The use of this new dental surgery should prove of

great benefit in the provision of treatment in this area of the City. There are now seven surgeries in the City, which corresponds with the establishment of dental officers. Of these surgeries, four are up to the accepted modern standard, and it is hoped that the remainder will be modernised in the near future.

Staffing.

Unfortunately, the section has not yet reached the full establishment of dental officers. At the beginning of the year there were 3 full-time and 2 part-time dental officers, an equivalent of $4 \frac{3}{11}$ ths dental officers. In December, Mrs. Ruddiman resigned her part-time appointment, thus further reducing the effective strength. For practical purposes, it can be said that there were 4 dental officers during the year.

Shortage.

Repeated advertising failed to attract any dentists into the service. The national shortage, and the inability to attract entrants to the local authority service, combined with the geographical position of Aberdeen, all account for this. The shortage of entrants to the profession has caused some concern, and this has been the subject of an enquiry during the past year by a Committee under the chairmanship of Lord M'Nair. The findings of this body are expected to be published in the late summer.

Dental Inspection.

The inspection of school children proceeded as in the previous year, that is, complete schools instead of specified age-groups as in the past. 124 half-days were spent on examining 19,425 children, and the parents of 14,484, or 75 per cent. of these, were notified that their children required dental treatment. The parents of 5,959, or 41 per cent. of these children, intimated acceptance by the School Service.

Dental Treatment.

At the end of the school year, 1,719 half-days had been spent in treating 5,066 systematic cases together with 592 special cases, a total of 5,658 children. Altogether, these made 11,236 attendances for 8,791 permanent and temporary fillings, 6,803 extractions of permanent and temporary teeth, and 4,028 other operations. The administrations of a general anæsthetic numbered 369, a decrease from the previous year.

In addition, 43 partial dentures were supplied to children, and repairs effected on other 3 dentures.

Orthodontic Treatment.

An innovation during the year which proved of great value was the use of an orthodontic consultant to advise on treatment. Mr. David Logie began to attend at the Central Clinic one half-day each month, and 99 children were seen by him. 8 of these were complicated, and were taken for treatment at the Orthodontic Clinic, Royal Aberdeen Hospital for Sick Children. Other 28 were supplied with

remediable appliances, and the remainder are under observation or having other treatment performed.

Pre-School Children.

The children in the four nursery schools and the four day nurseries were examined, and treatment carried out on those children whose parents accepted.

Expectant and Nursing Mothers.

The necessary treatment was given to those mothers referred by the medical officers from the ante-natal and post-natal clinics.

Future Needs.

A modern apparatus for general anæsthesia is a prime necessity for this regrettably necessary work, and a qualified anæsthetist for the administration.

Continued attempts should be made to try and recruit the full establishment of dental officers.

Acknowledgments.

Acknowledgments are due to the members of staff, without whose assistance the return of work would not have been possible, to Head Teachers for their co-operation, and to other departments for assistance during the year.

DENTAL INSPECTION AND TREATMENT, 1955-56.

	Systematic.	Special and Emergency Cases.	Total.
Number inspected	19,425	—	19,425
Number found to require treatment	14,484	—	14,484
Number accepting treatment	5,959	—	5,959
Number treated	5,066	592	5,658
Number of attendances for treatment	10,600	636	11,236
Fillings—			
(a) Permanent teeth	7,418	116	7,534
(b) Temporary teeth	1,229	28	1,257
			<hr/> 8,791
Extractions—			
(a) Permanent teeth	1,615	186	1,801
(b) Temporary teeth	4,545	457	5,002
			<hr/> 6,803
Number of administrations of a general anæsthetic	331	38	369
Other operations—			
(a) Permanent teeth	1,977	102	2,079
(b) Temporary teeth	1,892	57	1,949
			<hr/> 4,028
Inspection sessions	124	—	124
Treatment sessions	1,719	—	1,719

	Pre-School Children.	Expectant Mothers.	Nursing Mothers.
Number examined	440	10	8
Needing treatment	265	8	8
Number treated	144	8	7
Number of attendances	180	9	22
Number of fillings	52	13	12
Number of extractions	158	19	60
Number of general anæsthetics	42	5	2
Other operations	146	11	10
Dentures	—	4	4

IMMUNISATION.

(a) *Diphtheria Immunisation.*

The annual campaign of immunisation against diphtheria—mainly reinforcing doses among the five-year-old “entrants” and the eight-year-olds—was completed during the summer term. The following figures show the work done during the campaign. The corresponding figures for the last three years are given for comparison.

	1956.	1955.	1954.	1953.
Total number of visits paid to schools	104	127	101	88
Number of school children fully immunised for the first time (<i>i.e.</i> , 2 injections)	577	613	661	1,006
Number of school children who have received a reinforcing injection	4,617	4,205	3,714	3,504

The satisfactory response to the offer of a reinforcing injection continues to be encouraging. The number receiving initial (primary) immunisation is, of course, declining as more children secure primary immunisation before reaching school age.

At the end of June, 1956, 27,521 children of school age (or 92·4 per cent. of all children attending infant, primary, and secondary schools) had been immunised at some time.

(b) *Immunisation against Tuberculosis.*

The campaign to offer protection against tuberculosis to all pupils of 13 years and over was resumed in the autumn term, 1955. The necessary technique, which was fully described in the Annual Report for 1952-53, and including the tuberculin skin-test, mass miniature radiography, and inoculation with B.C.G. (of those found to be tuberculin negative), was carried out as before. Previous to this, “consents” had been received from the parents or guardians of 5,852, or 96·0 per cent., of these pupils—a very excellent response, comparable with the response of 96·7 per cent. last year and 91 per cent. in 1953 when the campaign started.

All pupils of 13 years and over were x-rayed by mass miniature radiography. Of these, 3,421 had been offered immunisation in previous years and were x-rayed only. Of the remainder, 46 pupils for various reasons had to be dropped from the scheme, *e.g.*, known contacts of cases of tuberculosis, children who left the district after acceptance, children whose x-ray plates showed signs of chest trouble, &c.

Actually, 2,385 pupils were tested for susceptibility to tuberculosis. Of these, 755 (or 31·7 per cent.) were tuberculin positive, *i.e.*, they had already acquired a "natural" immunity sufficiently high to make artificial immunisation unnecessary.

The remaining 1,630 (or 68·3 per cent.) were tuberculin negative, *i.e.*, had not acquired a "natural" immunity to tuberculosis and therefore were inoculated with B.C.G. vaccine.

At the end of six weeks (the minimum time for development of immunity) 156 (a sample 10 per cent. of the immunised pupils) were re-tested and were found to have been converted to tuberculin-positive reactors, *i.e.*, they had now become "insusceptible" to tuberculosis.

Following radiological examinations, 13 cases with minor chest lesions were kept under observation by the medical officer of the mass radiography unit, while 11 cases were referred to the Chest Clinic at the City Hospital. In all these cases, the appropriate medical practitioners were notified.

ARRANGEMENTS FOR PHYSICAL EDUCATION AND PHYSICAL HYGIENE.

The following information is presented by courtesy of Mr. T. S. Fairley, the Superintendent of Physical Education :—

Staff.

The Physical Education staff consists of the Superintendent, one Assistant Superintendent, twenty-eight female and sixteen male teachers. Of the female staff, nine are employed full-time in secondary and senior secondary schools, while the remaining nineteen are engaged in primary and secondary schools. Eight male teachers are attached to post-primary schools, the remainder being employed in both primary and secondary schools.

Four accompanists and one swimming instructor are also attached to the staff.

Students from Dunfermline College of Physical Education attend most of the Committee's schools for teaching practice.

Conferences.

Two conferences on Physical Education for Secondary School Girls were held during the session. The first, a one-day meeting at St. Andrew's House, Edinburgh, was followed by a three-day residential course and conference in the College of Physical Education, Aberdeen. The preliminary meeting in Edinburgh arose out of the many divergencies of opinion with regard to both content and method in the proposed new scheme.

The second conference, which followed upon the result of previous discussions, proved to be extremely comprehensive. The programme included discussions, demonstrations—both in college and in schools—films and lectures.

Both meetings, which were attended by the Department's inspectorate, lecturers from Dunfermline College and organisers, did much to remove many misconceptions and misunderstandings which had arisen concerning the proposed type of work for girls.

A new scheme of work for secondary school boys is also in course of preparation, and it is expected that the long-awaited memorandum from the Department on physical education in secondary schools will now be published at an early date.

Primary Schools.

After further delay, the final stage of the primary school scheme of work has been reached with the issue of the draft copy of the games section. It is hoped that, after many vicissitudes, the completed scheme will be published early next session.

Treatment of Physical Defects.

The remedial clinic at the College of Physical Education continues to function satisfactorily. During the past session, some sixty children attended the clinic twice weekly and received treatment for a variety of physical defects.

The clinic is visited regularly and the children examined by an orthopædic surgeon.

Playfields.

With the opening, at the beginning of the session, of Tullos playfield, the number of official playfields was increased to seven. In addition to the organised games played during school hours, the usual competitive team games were played on Saturdays and in the evenings. The comparatively open winter and the many spells of fine weather during the spring and summer terms enabled most of the competitions to be decided within the allotted time.

The new basketball trophy, so kindly donated by the Committee, was won for the first time by a team representing Kaimhill Secondary School.

Swimming.

The prolonged absence of Mr. Pirie, swimming instructor at the Middle School Pond, led to a curtailment of the usual swimming programme for a short period. We were fortunate, however, in again securing the services of that able exponent, Mrs. Ida Murdoch, who, on a previous occasion, proved herself to be a coach of considerable ability.

The usual classes for beginners were held in the Middle School pond. In addition, classes in life-saving were arranged for secondary school pupils who had gained the Committee's elementary certificate. During the session, 20,440 attendances were recorded, representing an average weekly attendance of 530.

Similar classes for beginners were organised at the Corporation ponds from March to October, when 11,342 attendances were reported, being an average of 516 pupils each week.

On completion of the courses, 712 pupils were awarded elementary certificates, while 87 candidates gained advanced certificates. In addition, 65 pupils were successful in gaining awards of the Royal Life-saving Society.

Schools' Sports.

The annual inter-school sports were held at King George's Field on the 19th and 20th June.

Every secondary school and practically all primary schools sent forward representative teams, and in both the preliminary heats and final events there were many close tussles for supremacy.

In the end, however, Mile-end School gained the coveted primary trophy for the second year by a good margin of points, while the neighbouring secondary school, Rosemount Secondary School, had the distinction of winning the secondary school flag for the third year in succession.

Once again, due acknowledgment must be made of the excellent service rendered by the many teachers whose ungrudging assistance did so much to ensure that the various competitions were carried through successfully.

OTHER ACTIVITIES IN RELATION TO SCHOOL CHILDREN.

(a) *Linn Moor Convalescent Home, Culter.*

During the year, 63 children (35 boys and 28 girls) were sent to this Home, as compared with 76 in the previous year. In addition, four batches of 56 children all told, sent to Linn Moor Home under the auspices of the Aberdeen Association of Social Service, were medically examined prior to leaving.

(b) *School Holiday Camps, 1956.*

During the months of June and July, the school medical officers visited all the junior secondary schools and seven primary schools for the purpose of inspecting batches of children who proposed going to the holiday camps. Each batch was inspected twice. Of 817 children finally examined, none had to be rejected because of unclean heads, and 11 because of failure to attend final inspection. This compares with the figures for the corresponding period last year of 953 children examined, 2 failures because of unclean heads and 3 because of absence.

(c) *Junior Club Camps, 1956.*

Visits of inspection were also paid in July to some primary schools for those younger children who belong to the appropriate junior clubs. In all, 244 children were finally examined, and only 3 had to be rejected because of unclean heads.

(d) *Senior Club Camps, 1956.*

Two hundred members of senior clubs were examined before going to various camps. All were fit to go to camp.

(e) School Meals.

The Director of Education has kindly supplied the following information about the School Meals Service. In all, there were 15 kitchens, including 5 nursery school kitchens. An average of 178 breakfasts were supplied each day. The price of a two-course lunch has remained at 8d. per meal during the year. Two-course lunches have been supplied daily during the year to an average of 5,771 pupils. Three-course lunches to the daily average number of 80 were supplied to pupils attending the Trades College.

(f) Milk.

The average number of bottles (one-third pint) of pasteurised milk supplied daily was 27,738.

TABLES.

The following tables are appended:—

- Table I. Numbers of children examined in the several age-groups.
 Table II. Return of number and percentage of individual children in each age-group suffering from particular defects.
 Table III. Classification of children examined at systematic medical examinations.
 Table IV. Return of all exceptional children of school age in the area.
 Table V. Average heights and weights—years 1935-56.

TABLE I.

Total number of children examined at—

(a) Systematic examinations—

Ordinary schools—

Entrants	2,835
Second age-group	3,023
Third age-group	2,411
Fourth age-group	—
Secondary Schools—Age-group	368

8,637

(b) Other examinations—

Special cases	2,597
Re-inspections by Medical Officers	6,916

9,513

Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanliness and dental caries):—

Entrants	143
Second age-group	273
Third age-group	196
Fourth age-group	—
Secondary age-group	20
	<hr/>
	632
	<hr/>

TABLE
SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Exam- ined. All ages.	ENTRANTS.			
		Boys 1,483		Girls 1,352	
1. Clothing unsatisfactory	8,637	1	·1	1	·1
2. Footgear unsatisfactory	"	—	—	1	·1
3. Cleanliness—					
(a) Head: Nits	"	—	—	6	·4
Vermin	"	—	—	—	—
(b) Body: Dirty	"	—	—	—	—
Vermin	"	—	—	—	—
4. Skin—					
(a) Head:					
Ringworm	"	—	—	—	—
Impetigo	"	4	·3	7	·5
Other Diseases	"	11	·7	4	·3
(b) Body:					
Ringworm	"	—	—	—	—
Impetigo	"	3	·2	—	—
Scabies	"	—	—	1	·1
Other Diseases	"	43	2·9	35	2·6
5. Nutritional state—					
Slightly defective	"	42	2·8	61	4·5
Bad	"	1	·1	4	·3
6. Mouth and Teeth Unhealthy	"	118	8·0	113	8·4
7. Naso-Pharynx—					
(a) Nose:					
(i) Obstruction requiring observation	"	107	7·2	93	6·9
(ii) Obstruction requiring Operative Treatment	"	9	·6	3	·2
(iii) Other Conditions	"	1	·1	—	—
(b) Throat:					
(i) Tonsils requiring observation	"	283	19·1	226	16·7
(ii) Tonsils requiring Operative Treatment	"	25	1·7	25	1·8
(c) Glands:					
(i) Requiring observation	"	107	7·2	80	5·9
(ii) Requiring Operative Treatment	"	—	—	—	—
8. Eyes—					
(a) External Diseases:					
Blepharitis	"	10	·7	14	1·0
Conjunctivitis	"	—	—	2	·1
Corneal Opacities	"	1	·1	—	—
Squint	"	96	6·5	94	7·0
Other Diseases	"	6	·4	7	·5
(b) Visual Acuity (Snellen):					
Defective—Fair	5,802	—	—	—	—
Bad	"	—	—	—	—
Recommended for Refraction	"	27	1·8	28	2·1
Number wearing Glasses	8,637	50	3·4	51	3·8
9. Ears—					
(a) Diseases:					
Otorrhœa	"	2	·1	4	·3
Other Diseases	"	43	2·9	28	2·1

II.

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,598		Girls 1,425		Boys 1,224		Girls 1,187		Boys 202		Girls 166		Boys 4,507		Girls 4,130	
1	·1	2	·1	—	—	1	·1	—	—	—	—	2	·04	4	·1
2	·1	—	—	—	—	1	·1	—	—	—	—	2	·04	2	·05
2	·1	4	·3	—	—	4	·3	—	—	—	—	2	·04	14	·3
2	·1	1	·1	—	—	1	·1	—	—	—	—	2	·04	2	·05
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
11	·7	2	·1	2	·2	—	—	—	—	—	—	17	·4	9	·2
8	·5	6	·4	5	·4	29	2·4	1	·5	3	1·8	25	·6	42	1·0
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	1	·1	1	·1	—	—	—	—	—	—	4	·1	1	·02
—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	·02
20	1·3	36	2·5	32	2·6	30	2·5	7	3·5	1	·6	102	2·3	102	2·5
19	1·2	26	1·8	9	·7	10	·8	—	—	—	—	70	1·6	97	2·3
1	·1	—	—	—	—	—	—	—	—	—	—	2	·04	4	·1
51	3·2	44	3·1	12	1·0	35	2·5	2	1·0	3	1·8	183	4·1	195	4·7
142	8·9	51	3·6	23	1·9	53	4·5	—	—	4	2·4	272	6·0	201	4·9
1	·1	2	·1	2	·2	—	—	—	—	—	—	12	·3	5	·1
3	·2	1	·1	2	·2	—	—	—	—	—	—	6	·1	1	·02
127	7·9	150	10·5	22	1·8	54	4·5	2	1·0	—	—	434	9·6	430	10·4
12	·8	13	·9	—	—	4	·3	—	—	—	—	37	·8	42	1·0
64	4·0	34	2·4	13	1·1	14	1·2	1	·5	—	—	185	4·1	128	3·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
30	1·9	27	1·9	12	1·0	28	2·4	—	—	1	·6	52	1·2	70	1·7
2	·1	—	—	—	—	1	·1	—	—	—	—	2	·04	2	·05
—	—	1	·1	—	—	1	·1	—	—	—	—	1	·02	2	·05
47	2·9	51	3·6	24	2·0	37	3·1	1	·5	—	—	168	3·7	182	4·4
13	·8	10	·7	2	·2	9	·8	—	—	—	—	21	·5	26	·6
222	13·9	228	16·0	208	17·0	197	16·6	52	25·7	26	15·7	482	15·9	451	16·2
50	3·1	65	4·6	65	5·3	65	5·5	6	3·0	10	6·0	121	4·0	140	5·0
92	5·8	90	6·3	65	5·3	89	7·5	7	3·5	12	7·2	191	6·3	219	7·9
127	7·9	136	9·5	121	9·9	160	13·5	39	19·3	22	13·3	337	7·5	369	8·9
9	·6	4	·3	4	·3	4	·3	1	·5	—	—	16	·4	12	·3
29	1·8	26	1·8	5	·4	30	2·5	—	—	—	—	77	2·5	84	2·0

TABLE
SYSTEMATIC

Return of number and percentage of individual children

NATURE OF DEFECT.	Total exam- ined. All ages.	ENTRANTS.			
		Boys 1,483		Girls 1,352	
9. Ears—(Continued)—					
(b) Defective Hearing :					
Grade I	5,802	—	—	—	—
Grade IIA	"	—	—	—	—
Grade IIB	"	—	—	—	—
Grade III	"	—	—	—	—
10. Speech—					
Defective articulation	8,637	46	3.1	18	1.3
Stammering	"	4	.3	2	.1
11. Mental and Nervous Conditions—					
(a) Backward	"	—	—	3	.2
(b) Dull	"	—	—	—	—
(c) Mentally deficient (Eduable)	"	—	—	—	—
(d) Mentally deficient (Ineducable)	"	—	—	—	—
(e) Highly nervous or unstable	"	28	1.9	21	1.6
(f) Difficult in behaviour	"	8	.5	15	1.1
12. Circulatory System—					
(a) Organic heart disease :					
(i) Congenital	"	6	.4	3	.2
(ii) Acquired	"	4	.3	—	—
(b) Functional conditions	"	6	.4	1	.1
13. Lungs—					
Chronic bronchitis	"	6	.4	17	1.3
Suspected tubercu-osis	"	11	.7	10	.7
Other diseases	"	59	4.0	15	1.1
14. Deformities—					
(a) Congenital	"	10	.7	9	.7
(b) Acquired (Infantile paralysis)	"	7	.5	4	.3
(c) Acquired (Probably rickets)	"	30	2.0	40	3.0
(d) Acquired (Other causes)	"	59	4.0	52	3.8
15. Infectious diseases	"	2	.1	—	—
16. Other diseases or defects	"	261	17.6	198	14.6
17. Classification :					
Group I	"	533	35.9	538	39.8
Group IIA	5,802	—	—	—	—
Group IIB	8,637	32	2.2	25	1.8
Group IIC	5,802	—	—	—	—
Group III	8,637	729	49.2	622	46.0
Group IVA	"	158	10.7	143	10.6
Group IVB	"	31	2.1	24	1.8
Number Notified to parents	"	80	5.4	63	4.7
Number under observation	"	833	56.2	728	53.8
Number of Parents present	"	1,418	95.6	1,302	96.3

II (Continued.)

EXAMINATIONS.

in each age-group suffering from particular defects.

SECOND AGE-GROUP.				THIRD AGE-GROUP.				FOURTH AGE-GROUP.				ALL AGES.			
Boys 1,598		Girls 1,425		Boys 1,224		Girls 1,187		Boys 202		Girls 166		Boys 4,507		Girls 4,130	
5	·3	2	·1	8	·7	2	1·7	—	—	—	—	13	·4	4	·1
2	·1	2	·1	4	·3	1	·1	1	·5	—	—	7	·2	3	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
8	·5	7	·5	2	·2	1	·1	—	—	—	—	56	1·2	26	·6
4	·3	1	·1	4	·3	—	—	—	—	—	—	12	·3	3	1
1	·1	2	·1	2	·2	—	—	—	—	—	—	3	·1	5	·1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
16	1·0	10	·7	4	·3	11	·9	1	·5	1	·6	49	1·1	43	1·0
5	·3	3	·2	—	—	2	·2	—	—	—	—	13	·3	20	·5
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
3	·2	3	·2	2	·2	—	—	1	·5	1	·6	9	·2	7	·2
2	·1	4	·3	1	·1	8	·7	—	—	1	·6	8	·2	13	·3
—	—	6	·4	—	—	1	·1	1	·5	—	—	9	·2	8	·2
2	·1	—	—	4	·3	2	·2	—	—	2	1·2	12	·3	21	·5
8	·5	13	·9	3	·2	6	·5	—	—	1	·6	22	·5	30	·7
49	3·1	31	2·2	12	1·0	16	1·3	2	1·0	1	6	122	2·7	63	1·5
11	·7	11	·8	5	·4	7	·6	—	—	2	1·2	26	·6	29	·7
8	·5	7	·5	2	·2	2	·2	—	—	—	—	17	·4	13	·3
19	1·2	17	1·2	3	·2	14	1·2	—	—	1	·6	52	1·2	72	1·7
41	2·6	35	2·5	10	·8	22	1·9	5	2·5	1	·6	115	2·6	110	2·7
1	·1	1	·1	—	—	—	—	—	—	—	—	3	·1	1	·02
215	13·5	171	12·0	35	2·9	129	10·9	6	3·0	26	15·7	517	11·5	524	12·7
684	42·8	622	43·6	744	60·8	569	47·9	119	58·9	100	60·2	2,080	46·2	1,829	44·3
134	8·4	153	10·7	246	20·1	147	12·4	57	28·2	28	16·9	437	14·5	328	11·8
19	1·2	21	1·5	1	·1	15	1·3	—	—	2	1·2	52	1·2	63	1·5
2	·1	3	·2	—	—	1	·1	—	—	—	—	2	·1	4	·1
624	39·0	500	35·1	166	13·6	354	29·8	13	6·4	26	15·7	1,532	40·0	1,502	36·4
84	5·3	78	5·5	45	3·7	47	4·0	11	5·4	4	2·4	298	6·6	272	6·6
51	3·2	48	3·4	22	1·8	54	4·5	2	1·0	6	3·6	106	2·4	132	3·2
135	8·4	138	9·7	69	5·6	127	10·7	8	4·0	12	7·2	292	6·5	340	8·2
671	42·0	585	41·1	279	22·8	404	34·0	39	19·3	43	25·9	1,822	40·4	1,760	42·6
424	89·1	1,306	91·6	694	56·7	806	67·9	51	25·2	55	33·1	3,587	80·0	3,469	84·0

TABLE III.
SYSTEMATIC MEDICAL EXAMINATIONS.

CLASSIFICATION	ENTRANTS		SECOND AGE-GROUP		THIRD AGE-GROUP		FOURTH AGE-GROUP		TOTAL	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the children examined at systematic examinations
I. Children free from defects	1,071	37.8	1,306	43.2	1,313	54.5	219	59.5	3,909	45.3
II. Children (otherwise free from defects) who suffer from—										
(a) Defective vision not worse than 6/12 in the better eye with or without glasses	—	—	287	9.5	393	16.3	85	23.1	765	8.9
(b) Oral Sepsis, etc.	57	2.0	40	1.3	16	.7	2	.5	115	1.3
(c) Both (a) and (b)	—	—	5	.2	1	.04	—	—	6	.1
Total	57	2.0	332	11.0	410	17.0	87	23.6	886	10.3
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks	1,351	47.7	1,124	37.2	520	21.6	39	10.6	3,034	35.1
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. and III., distinguishing cases—										
(a) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible	301	10.6	162	5.4	92	3.8	15	4.1	570	6.6
(b) Where improvement only is considered possible, e.g., without complete restoration of function	55	1.9	99	3.3	76	3.2	8	2.2	238	2.8
Total	356	12.6	261	8.6	168	7.0	23	6.2	808	9.4
Total number of children examined	2,835	100%	3,023	100%	2,411	100%	388	100%	8,637	100%

TABLE IV.

RETURN OF ALL EXCEPTIONAL CHILDREN OF SCHOOL AGE IN THE AREA.

DISABILITY	At Ordinary Schools	At Special Schools or Classes	At no School or Institution	TOTAL
1. Blind	—	7	—	7
2. Partially sighted—				
(a) Refractive errors in which the curriculum of an ordinary school would adversely affect the eye condition	—	2	—	2
(b) Other conditions of the eye, <i>e.g.</i> , cataract, ulceration, &c., which render the child unable to read ordinary school books or to see well enough to be taught in an ordinary school	—	10	—	10
3. Deaf—				
Grade I	335	—	—	335
Grade IIA	45	—	—	45
Grade IIB	—	21	—	21
Grade III	—	43	—	43
4. Defective Speech—				
(a) Defects of articulation requiring special educational measures	760	59	—	819
(b) Stammering requiring special educational measures	365	19	—	384
5. Mentally defective children (between 5 and 16 years)—				
(a) Educable (I Q. approx. 50-70)	—	199	—	199
(b) Trainable	—	40	4	44
(c) Ineducable	—	—	12	12
6. Epilepsy—				
(a) Mild and occasional	21	16	—	37
(b) Severe (suitable for care in a residential school)	—	—	—	—
7. Physically defective children (between 5 and 16 years)—				
(a) Non-pulmonary tuberculosis (excluding cervical glands)	6	1	—	7
(b) General orthopaedic conditions	152	19	3	174
(c) Organic Heart Disease	117	5	—	122
(d) Other causes of ill-health	—	6	—	6
8. Multiple defects—				
(a) Mentally defective and deaf	—	33	—	33
(b) Physically defective and mentally defective	—	30	1	31
(c) Mentally defective (ineducable) and blind	—	—	1	1

TABLE V.—HEIGHTS AND WEIGHTS, 1935-1956.

Boys.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.
1935-36	5 3	41·9	40·4	9 0	49·9	58·6	...	...	...	...	...	16 0	66·2	125·1	...	...
1936-37	5 3	41·8	40·4	9 0	50·0	58·8	...	...	...	...	...	16 0	65·4	126·7	...	...
1937-38	5 3	41·8	40·7	9 0	50·3	59·6	...	...	...	...	...	16 0	66·7	129·6	...	...
1938-39	5 3	42·0	41·0	9 6	51·3	60·9	13 6	58·6	90·9	67·7	135·0	16 5	67·7	135·0	...	...
1939-40	5 4	42·3	41·6	9 6	50·9	61·3	13 6	58·5	89·8	67·0	134·1	16 6	67·0	134·1	...	...
1940-41	5 3	41·9	41·3	9 4	50·7	60·8	13 5	58·4	88·2	67·1	132·0	16 4	67·1	132·0	...	...
1941-42	5 4	42·0	41·4	9 4	50·8	61·1	13 4	58·3	88·3	67·4	133·2	16 5	67·4	133·2	...	...
1942-43	5 3	42·0	41·2	9 4	50·8	60·8	13 4	58·5	88·8	67·5	134·0	16 5	67·5	134·0	...	...
1943-44	5 3	42·0	41·8	9 5	50·9	62·0	13 5	58·6	89·4	67·4	134·7	16 7	67·4	134·7	...	...
1944-45	5 3	42·2	42·0	9 4	51·0	61·8	13 4	58·4	89·4	67·5	133·5	16 4	67·5	133·5	...	...
1945-46	5 3	42·4	42·1	9 5	51·0	62·2	13 5	58·7	90·1	67·5	134·3	16 6	67·5	134·3	...	...
1946-47	5 2	42·3	41·7	9 2	51·1	62·0	13 5	58·7	90·4	67·6	130·0	16 6	67·6	130·0	...	...
1947-48	5 2	42·3	41·8	9 5	51·1	62·4	13 4	58·7	90·6	67·5	134·5	16 6	67·5	134·5	...	...
1948-49	5 3	42·4	42·4	9 5	51·3	63·3	13 5	58·8	91·4	67·7	134·3	16 6	67·7	134·3	...	...
1949-50	5 3	42·8	42·8	9 5	51·6	63·6	13 5	59·0	91·6	67·6	135·3	16 6	67·6	135·3	...	...
1950-51	5 3	42·5	42·8	9 3	51·5	63·1	13 5	59·1	92·5	67·4	133·3	16 5	67·4	133·3	...	...
1951-52	5 3	42·7	42·9	9 4	51·3	63·0	13 5	59·9	93·1	68·0	136·3	16 5	68·0	136·3	...	...
1952-53	5 3	42·5	42·4	9 4	51·6	62·9	13 7	59·3	93·3	68·3	132·3	16 5	68·3	132·3	...	...
1953-54	5 3	42·3	42·1	9 4	51·5	63·9	13 5	59·6	93·7	67·7	133·6	16 6	67·7	133·6	...	...
1954-55	5 2	42·4	42·4	9 4	51·7	64·3	13 5	59·5	94·1	67·8	138·5	16 5	67·8	138·5	...	...
1955-56	5 3	42·5	42·2	9 4	51·7	64·3	13 5	59·5	94·4	67·8	134·4	16 5	67·8	134·4	...	...

Girls.

Year	GROUP I.—5 YEARS				GROUP II.—9 YEARS				GROUP III.—13 YEARS				GROUP IV.—16 YEARS			
	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	Yrs. Mths.	Average Age	Average Height in Inches	Average Weight in Lbs.	
1935-36	5	3	41.3	9	0	49.6	55.9	13	6	59.6	94.4	16	4	63.6	118.8	
1936-37	5	3	41.4	9	0	49.6	56.1	13	5	58.9	92.7	16	6	63.6	119.2	
1937-38	5	3	41.7	9	0	50.1	56.8	13	5	59.0	91.6	16	6	63.8	120.7	
1938-39	5	3	41.7	9	7	51.1	60.5	13	6	59.6	94.4	16	4	63.6	120.2	
1939-40	5	4	41.9	9	6	50.4	59.3	13	5	58.9	92.7	16	6	63.6	120.5	
1940-41	5	3	41.7	9	4	50.2	58.5	13	5	59.0	91.6	16	6	63.6	120.5	
1941-42	5	3	41.6	9	4	50.3	58.6	13	4	58.8	92.0	16	5	64.0	122.3	
1942-43	5	3	41.8	9	4	50.4	58.2	13	4	59.3	92.2	16	6	63.9	120.6	
1943-44	5	3	41.6	9	5	50.4	59.4	13	5	59.3	93.4	16	7	64.4	124.8	
1944-45	5	3	41.9	9	5	50.3	60.5	13	5	59.3	93.4	16	6	63.6	123.8	
1945-46	5	3	41.7	9	6	50.6	60.4	13	5	59.4	94.9	16	6	63.1	121.7	
1946-47	5	2	42.7	9	5	50.7	60.3	13	4	59.3	92.6	16	6	64.2	124.2	
1947-48	5	2	42.0	9	5	50.8	60.6	13	5	59.4	94.8	16	5	63.8	123.2	
1948-49	5	3	42.4	9	5	50.9	61.5	13	5	59.6	96.5	16	5	64.0	123.9	
1949-50	5	3	42.1	9	5	51.0	61.3	13	6	59.6	95.9	16	6	63.9	120.9	
1950-51	5	3	42.1	9	5	51.4	61.1	13	4	59.5	96.1	16	6	63.9	120.3	
1951-52	5	3	42.0	9	5	51.1	61.4	13	5	59.8	97.7	16	6	63.8	123.6	
1952-53	5	3	41.9	9	5	51.0	61.2	13	5	59.8	97.1	16	6	63.9	123.4	
1953-54	5	3	42.0	9	4	50.8	61.5	13	5	59.7	97.0	16	6	63.8	123.2	
1954-55	5	3	42.1	9	3	50.9	62.1	13	5	59.8	99.1	16	4	64.0	124.5	
1955-56	5	3	42.1	9	4	51.3	62.6	13	5	59.9	99.4	16	5	63.8	126.6	

18.—PORT HEALTH ADMINISTRATION.

The control of port health and port sanitary work is a duty of the Medical Officer of Health in his capacity as Port Medical Officer.

This work involves the inspection of fish, markets, premises, fishing vessels and other ships, and is carried out by the staff of the sanitary section of the Health and Welfare Department. The duties take the full time of one District Sanitary Inspector and part of the time of a second. A review of this part of the work will be given by the Chief Sanitary Inspector in his Annual Report.

The prevention of the introduction of infectious diseases to the port and thence to the country is dealt with in the Public Health (Ships) (Scotland) Regulations, 1952; these regulations describe the action to be taken by the master of a ship if infectious disease on board is known or suspected or if the ship has come from an infected port. They describe also the action to be taken by the Port Medical Officer under these circumstances. During the year, ships from foreign countries entered the port on 350 occasions, and on 274 of these occasions were boarded by a sanitary inspector.

Throughout the year, a list of countries considered infected by plague, cholera, yellow fever, smallpox, typhus, and relapsing fever was compiled weekly by the Medical Officer of Health from information supplied by the World Health Organisation; copies of this list were supplied weekly to the customs authorities, sanitary inspectors, and medical officers of the department.

During the year, 31 ships entered the port from these infected areas, and all of these 31 came from North African ports. Satisfactory declarations of health were received from all 31, all were boarded by appropriate officers, and no cases of genuine or suspected infectious disease were found.

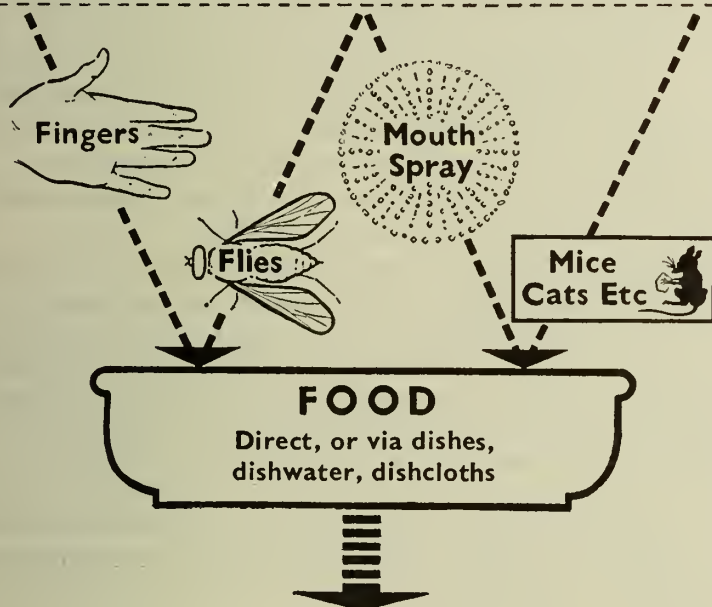
19.—FOOD SUPPLY AND FOOD HYGIENE.

During the year, the Food and Drugs (Scotland) Act, 1956, came into operation and, in effect, repealed the Food and Drugs (Adulteration) Act, 1928, and the Food and Drugs Act of 1938. The main provisions of the Act bring up to date the procedure for dealing with the composition and labelling of food and drugs, the procedure to be taken in connection with the prohibition of food unfit for human consumption, and the registration of certain manufacturers and traders. The Act also makes it compulsory for all cases of food poisoning to be notified to the Medical Officer of Health, and this portion of the Act came into effect as at 1st August, 1956. Under the Act, the Secretary of State for Scotland can make certain regulations for securing the observance of sanitary and cleanly conditions and practices in connection with the sale of food for human consumption or the importation, preparation, transport, storage, exposure for sale, service, or delivery of food intended for sale or sold for human consumption or otherwise for the protection

TRANSFER OF INFECTIONS BY FOOD

SECRETIONS & EXCRETIONS OF PATIENT OR GERM CARRIER

Bowel · Bladder · Nose and Throat
Discharging Ear · Septic Cut · Boil



ANOTHER VICTIM

Typhoid	·	Paratyphoid	·	Dysentery
Food Poisoning			·	Poliomyelitis
		<i>and sometimes</i>		
Tuberculosis	·	Scarlet Fever	·	Diphtheria
Erisipelas			·	Trench Mouth

of the public health in connection with the matters aforesaid, and it is hoped that regulations may soon be made to enable local authorities to deal with these conditions.

In this connection, a special Clean Food Guide—an illustrated booklet of some fifty pages—was prepared by the staff of the Health and Welfare Department and published by Batiste Publications, Limited, London, containing information and guidance on clean food, and just after the end of the year 3,000 copies of the booklet were made available for distribution at clinics and parents' clubs and to catering establishments and similar agencies. A page from the booklet is inserted by way of illustration.

In the examination of food samples, the bacteriologist has begun to play an even bigger part than the biochemist in advising on the important subject of food hygiene, and it has become imperative that the Medical Officer take an active part instead of delegating this work entirely to the Sanitary Inspector. Also, since the biggest normal handler of food is the housewife, it has become obvious that the health visitor, with her unrivalled direct access to the home and her skill in teaching, has a big part to play—perhaps the biggest part of all. All three—medical officer, health visitor, and sanitary inspector—must work as a team.

It may be noted in passing that no case of food-borne disease during the year has been attributed to defects of food-handling in shops.

It is not proposed to discuss here certain matters which are, in the main, undertaken by the Sanitary Section but simply to indicate that the administration of the Acts, Orders, and Bye-laws relating to milk, the details of milk samples examined during the year, and the administration of the Ice-Cream (Scotland) Regulations, 1948, will be outlined in the Annual Report of the Chief Sanitary Inspector. His report will also contain certain information about food premises inspected, defects found and remedied, and assessments of hygienic standards attained.

Mention may, however, be made of some points in connection with meat and other foods. Of the four private slaughter-houses licensed within the Burgh, two belong to the Flesher Incorporation, and all were in operation during the year, either continuously or intermittently.

The following is a summary of the animals slaughtered and the results of the inspection of the carcasses:—

Class of Animal.	Total Slaughtered.	Carcasses totally Condemned.	Carcasses partially Condemned.	Weight (in lbs.) of Condemned Meat.
Cattle	74,820	185	285	148,917
Sheep	108,673	290	143	15,044
Pigs	2,532	48	169	9,840
Calves	696	73	2	3,289
	186,721	596	599	177,090

In addition, 109,965 lbs. of offal was condemned. The total weight of condemned meat and offal amounted to 287,055 lbs.

During the year, there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some seventy-six licences were issued for the use of the mechanically-operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to diseases of animals was duly carried out. During 1956, there was no outbreak of swine fever.

During the year, no particular food hygiene campaigns were undertaken and no special action was taken in respect of general nutrition; but all members of the staff of the Health and Welfare Department—doctors, health visitors, sanitary inspectors, &c.—continued to exercise an educative influence on the public.

20.—SERVICES UNDER NATIONAL ASSISTANCE ACT, &c.

During 1956, there was continued general expansion of the services provided to maintain the physical and emotional health and social well-being of elderly persons and to meet the needs of the aged and infirm. In particular—

- (1) The number of names on the department's register of old people rose from 1,350 in 1955 to just over 2,000.
- (2) The number of elderly citizens receiving visits from health visitors rose from 1,238 in 1955 to 2,320.
- (3) 2,163 persons over 65 years received visits from home nurses on day duty and 266 received the benefits of the night nursing service.
- (4) Home helps were supplied to 778 persons over 65 years of age, as compared with about 600 in the previous year.
- (5) The meals-on-wheels service supplied more meals than ever before.
- (6) The chiropody service continued to expand and a full-time chiropodist was appointed.
- (7) At 31st December, the Corporation was accommodating 199 infirm old people in its homes and was contributing towards the maintenance of 50 others in voluntary homes.
- (8) Towards the end of the year, a comprehensive investigation into the circumstances and needs of a 5 per cent. sample of all elderly persons in the City was commenced.

General.

When the National Health Service (Scotland) Act, 1947, and the National Assistance Act, 1948, came into operation, the Corporation decided to combine the former Health Committee and Welfare Committee and to appoint the Medical Officer of Health as principal officer of a combined Health and Welfare Department. The very considerable advantages of this arrangement, which in practice works admirably, have been indicated in previous reports.

Provision of Accommodation for Elderly, &c.

Section 21 of the National Assistance Act, 1948, places on local authorities a duty to provide residential accommodation for aged and infirm persons who cannot adequately look after themselves but who do not require the skilled medical treatment or continuous nursing care available in a hospital. When the Act came into operation, the only accommodation for the aged and infirm belonging to the Corporation was at Woodend Home. This (being quite unsuitable for active persons but capable for adaptation for hospital use) was sold to the Regional Hospital Board in 1951, although one of the conditions of sale was that a portion of the accommodation would remain available for aged and infirm persons for a period of seven years.

Since 1948, the Corporation have acquired or built hostels as follows:—

- (1) Balnagask House was adapted and opened in December, 1950, as a home for 25 persons.
- (2) Nos. 3-5, Ferryhill Place, were adapted and opened in November, 1951, and November, 1953, respectively, and have been converted into a single home for 24 persons.
- (3) Northfield Lodge was specifically erected and opened in April, 1953, as a home for 40 persons.
- (4) No. 30, Albyn Place, was adapted and opened in February, 1954, as a home for 24 persons.
- (5) Newhills Home, purchased from the Regional Hospital Board, was adapted and opened in March, 1955, with accommodation for 46 residential cases and 6 temporary cases, together with a Reception Centre for females and dependants.
- (6) No. 19, Polmuir Road, was extensively adapted and opened in May, 1955, as a home for 32 persons.
- (7) Work has now commenced on the conversion of the former residential nursery at Thorngrove into another home.

During 1956, the National Assistance Board decided to terminate the arrangement whereby Reception Centre accommodation was provided by the Corporation, and four places reserved for this purpose in Newhills Home became available for ordinary residential accommodation. At the end of the year, the total accommodation available was, therefore, 195 places with a further 50 places under construction at Thorngrove, and additional accommodation at Newhills envisaged.

In addition, the Corporation has entered into an agreement with the Aberdeen Old People's Welfare Council, a voluntary body which has acquired four large houses for the reception of aged persons. By this agreement, the Corporation pay for the maintenance in these homes of Aberdeen persons who are financially unable to meet the charges personally. Similar arrangements have been made with the owners of the King Street Hostel, St. Margaret's Hostel, and with the Church of Scotland

Committee on Social Service; these bodies receive into their homes certain aged and infirm persons who require accommodation which the Corporation cannot themselves provide, and the Corporation bears such proportion of the cost of maintenance as the persons are not able to meet.

At 31st December, 1956, the number of aged and infirm in residential accommodation (whether belonging to the local authority or to voluntary organisations) in respect of whom the Corporation make a contribution towards the cost of maintenance was as follows:—

<i>Local Authority Homes—</i>		Male.	Female.	Total.
No. 30, Albyn Place		6	14	20
Balnagask House		12	13	25
Nos. 3-5, Ferryhill Place		10	11	21
Newhills Home		21	22	43
Northfield Lodge		10	29	39
No. 19, Polmuir Road		6	24	30
Glenburn Wing of Woodend Hospital		13	8	21
<i>Voluntary Homes—</i>				
Aberdeen Old People's Welfare Council		11	18	29
Church Homes		2	3	5
King Street Hostel		—	1	1
St. Margaret's Hostel		—	13	13
<i>Homes in other Areas</i>		2	—	2
Totals		93	156	249

These figures do not include dispossessed persons temporarily accommodated at Newhills Home (viz., 1 female and 7 dependants on 31/12/56), nor do they include residents temporarily in hospital whose places in the homes are reserved pending their return. As compared with the totals at the end of 1955, there was no significant change in the number accommodated in local authority homes other than Glenburn Wing, where there was a substantial reduction from 46 to 21.

Medical Supervision in Residential Accommodation.

With a view to optimal utilisation of vacancies available, all applicants for admission to residential accommodation are now interviewed in their own homes or elsewhere by the Principal Assistant Medical Officer who also pays periodic visits to the Corporation homes to supervise the hygienic aspects of each home and to give advice about diet, heating, ventilation, and so on. All the residents have a free choice of private doctor and receive personal medical care in the same way as do any other members of the community. This system works satisfactorily.

In 1956, as in past years, it was necessary, owing to the deterioration in the condition of some few residents, to have them transferred to the chronic sick wards of one of the hospitals. In close liaison with the hospital authorities, suitable two-way arrangements were made in one or two cases whereby convalescent patients were transferred from hospital to hostel and sick patients from hostel to hospital.

Cottages for the Elderly.

The Corporation erected in the Kaimhill and Northfield areas, houses consisting of one room and a bedroom annexe together with a bathroom, for elderly couples. In certain other areas, the Corporation have erected similar types of houses and these houses have now been classified as special purpose houses and are not only for elderly couples but also for certain other classes.

General Provisions for Elderly Persons.

To keep elderly persons fit and healthy in their own homes is a task even more important than the provision of special hostels. It may be convenient to summarise here some provisions made by the Corporation for the health and welfare of the elderly in their own homes:—

(1) *Visitation of the elderly by health visitors.*—These visits have now fully proved their value, and the unification of the Health and Welfare Department is most helpful in that the health visitor (the person on whom rests the statutory duty of advising the whole family on many matters of physical and emotional health) can bring her expert knowledge and experience to bear on the health problems and social problems of the elderly individual. The health visitor's advice on diet, clothing, proper balance on rest and exercise, and about the development of leisure interests in preparation for retirement, can be of supreme importance in maintaining the health of persons of ripe years; and, where an old person is beginning to need assistance (*e.g.*, a home help, or the mobile service or chiropody) the health visitor can assess the need and initiate any necessary action. Again, when an old person becomes perplexed about the various allowances possibly available to him, the health visitor can frequently remove his confusion.

Less than one elderly citizen out of each hundred visited expresses himself as not desiring visits by health visitors. In these very exceptional cases, visiting is, of course, discontinued.

During 1956, 2,320 elderly citizens received visits from health visitors—an increase of 87 per cent.

(2) *Home Help Service.*—Details are given in an earlier section, but it may be noted here that the amount of attention devoted to old people is steadily increasing, and the bulk of the work of this service is now performed in the households of the elderly, usually on a basis of two or three mornings per week per person. During 1956, 778 persons over 65 years of age received such assistance.

(3) *Home Nursing Service.*—This is described elsewhere, but 47 per cent. of cases dealt with by the district nurses on the day service and 79 per cent. of the cases of the nurses on the night service were persons over 65 years of age. The comparable figures for 1955 were 45 per cent. and 75 per cent., respectively.

(4) *Chiropody Service.*—A new development in the steady expansion of this very beneficial service (which is fully discussed in the section relating to care and

after-care) was the appointment of a full-time chiropodist, who took up duty in June, 1956. The service enables many people who would otherwise have become housebound to remain ambulant.

(5) *Meals-on-wheels Service*.—This service is run by the W.V.S. and subsidised by the Corporation, who paid £243 6s. 8d. for 7,300 meals supplied during the year, as compared with £220 18s. 8d. for 6,628 meals in 1955—an increase of 10 per cent.

The scope of the meals service in its relationship to the home help service was the subject of detailed investigation. Further expansion of the meals service was found to be desirable, and the Corporation agreed to pay £40 for additional food containers for use by the W.V.S.

(6) *Register of Old Persons*.—During the year nearly 900 names were added to the register, which now stands at a total of about 2,000 old people. The register is of invaluable assistance in the co-ordination of services for old people and in the follow-up of cases.

The main needs found in persons placed on the register continue to be—in descending order of frequency—visiting by health visitors, treatment by general practitioners, services of home helps, chiropody, and financial assistance.

Survey of Elderly Persons.

Towards the end of the year a comprehensive survey of elderly persons in Aberdeen was commenced under the general direction of the Principal Assistant Medical Officer. The main object of this investigation is to obtain more precise knowledge of the circumstances and needs of the elderly populace by study of a random sample of households in conjunction with a census of old persons in hospitals, nursing homes, hostels, &c.

There are many aspects of old age concerning which very little is known, and for really efficient planning of services such basic information as may be gleaned from an investigation of this nature will certainly be most helpful.

WELFARE SERVICES (Section 29).

(a) Physically Handicapped Adults.

The scheme for physically handicapped persons, as approved by the Secretary of State in 1953, has been in operation for three years. There are at present 325 persons on the register (as compared with 319 in 1955), but a total of 369 have been registered since the commencement of the scheme. The reduction in numbers is accounted for by deaths and removals to other areas.

The visiting pattern for these people has remained much the same during the last year as in the two previous years.

A proportion still required frequent visiting. Occasionally, material help was obtained from other public and voluntary organisations; for example, a few people benefited from holidays which afforded them a complete change from their normal

environment. The money was provided, in the main, by one of the local voluntary organisations.

After initial enquiries and requests by the local authority, the National Assistance Board, in some cases, granted special allowances to meet additional expenses such as removal costs.

Several registered disabled persons have been suitably rehoused during the year. There is still, however, a need for more ground-floor accommodation, including special purpose dwellings for those who are handicapped and single.

The employment position has remained difficult but an attempt is being made to interest a small group of employers in the needs of the more severely disabled.

The arrangement has continued whereby severely handicapped sighted persons or partially sighted persons may be given the opportunity of training and employment in the Aberdeen Asylum for the Blind if they are suitable and other means of employment are found impossible.

The financial position for the long term unemployed disabled has remained very difficult. With frequently increasing costs, these people, living on a more or less fixed income, sometimes suffer real hardship and deprivation. In several cases, it has been possible for the local authority to obtain financial assistance from various voluntary funds.

As yet there is no occupational centre for the physically handicapped, but the need remains and suitable premises are still being sought.

As with each Local Authority Welfare Service, close contact has been maintained with other interested organisations.

(b) Blind Persons.

A clinic for the examination and ascertainment of blind persons is held each month at Woolmanhill, and is staffed by two consultants employed by the North-Eastern Regional Hospital Board and by a health visitor employed by the Corporation. The Corporation carry out their responsibility for the blind under the Act through the agency of the Royal Aberdeen Asylum for the Blind, who provide training and employment in their workshops in Aberdeen, and the Aberdeen Association for the Teaching of the Blind at their Homes, who employ home teachers for the training of the blind and provide certain welfare services. In addition, the Corporation utilise the services provided by certain other voluntary organisations. The following is a summary of the organisations and the payments made to them:—

Royal Aberdeen Asylum for the Blind.—For the financial year ended 31st May, 1956, the Corporation paid to the Royal Aberdeen Asylum for the Blind the sum of £274 9s. 6d. in respect of each City worker registered under the Disabled Persons (Employment) Act, 1944. There were 49 workers employed and the total cost to the Corporation was £13,472 9s. 4d., of which sum a grant at the rate of £100 per annum for each worker employed for a full year was recovered from the Ministry of Labour and National Service, making the net expenditure to the Corporation £8,559 17s. 5d.

Aberdeen Association for Teaching the Blind at their Homes.—The sum of £3 15s. per annum is paid in respect of each certified blind person from Aberdeen on their roll. In addition, a grant of £20 per annum is made to the Association in respect of home workers who are assisted financially by the Association. At the end of the last financial year there were 271 certified blind persons on the roll, including 4 home workers, and the sum of £1,108 was paid by the Corporation to the Association.

Royal Blind Asylum, Edinburgh.—Two home workers are employed in Aberdeen, but are attached to the Edinburgh Home Workers' Scheme, and grant at the rate of £30 per annum for each of them is paid to the Royal Blind Asylum, Edinburgh.

Thomas Burns Homes, Edinburgh.—Two persons belonging to the City of Aberdeen reside in the Homes and are maintained by the Corporation. The net cost of maintenance for the two inmates during the year was £117.

Book Production Grant.—£90 per year.

Donation to the National Library for the Blind.—£32 10s. per year.

Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—For the previous three years the Corporation had received no applications, but in 1956 a holiday period was arranged for one blind person.

The number of blind persons on the Register of the Blind as at 31st December, 1956, was 351. The numbers according to the different age-groups are as follows:—

0-2		3-4		5-15		16-17		18-29		30-39		40-49		50-69		70+		TOTAL		
M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	T.
—	—	—	1	3	4	—	—	5	3	15	6	21	25	54	75	50	89	148	203	351

During 1956, 34 persons were examined for the first time, 24 at the Blind Persons' Clinic and 10 at their homes. Re-examination was made of 31 persons.

The total number of persons examined was 65 as compared with 71 in 1955.

Of the 34 persons examined for the first time, 24 (or 71 per cent.) were certified blind within the meaning of the Blind Persons Act.

Of the 8 children registered blind, 4 were attending school at Craigmillar and 3 were ineducable.

The following statement gives the number of blind persons of 16 years and upwards who were in employment at 31st December, 1956:—

(a) In Institutions for the Blind—		Males.	Females.
Undergoing industrial training	. . . . .	10	2
In workshops	. . . . .	39	12
(b) Outwith Institutions for the Blind*	. . . . .	10	3

* Including 6 home workers (5 males and 1 female).

(c) Deaf and Dumb Persons.

Under the National Assistance Act, 1948, the Corporation are empowered to make provision for the training of deaf and dumb persons and also for their welfare.

Pending the development of a fuller scheme, a payment of £447 15s. was made to the Aberdeen Deaf and Dumb Benevolent Society for the year 1955-56 in respect of certain welfare services provided by the Society.

(d) Provision of Temporary Accommodation for Persons in Urgent Need, and Sundry Other Services.

During the year temporary accommodation was provided for 46 persons in urgent need arising in circumstances which could not reasonably have been foreseen.

In addition, 612 cases of casual nature were dealt with, arising from domestic upset, acute housing needs, &c., and requiring general welfare services and assistance to meet their needs or overcome their specific difficulties.

These figures represent considerable increases over 1955, when accommodation was provided for 22 persons and 274 others were dealt with.

(e) Registration and Inspection of Homes for Disabled or Old People's Homes.

Under the National Assistance Act, no persons may open a home for the disabled and old persons without the home being registered by the appropriate local authority. During the year there were no further applications for registration, and the total number of Homes registered in the City is 8.

(f) Section 48—Care and Protection of Property of Persons Admitted to Hospital or to Local Authority or Voluntary Hostels.

Care, protection, and storage was provided in 255 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which otherwise would retard the recovery of patients. In addition, 472 Old-Age Pensions, &c., were negotiated on behalf of pensioners during hospitalisation and periods of accommodation to ensure the provision of extra comforts and to defray general personal commitments while under care or treatment.

(g) Section 50—Burial or Cremation of the Dead.

During the year, 61 persons—35 men, 22 women, and 4 children—were dealt with under this section.

(h) Reception Centre—Section 17 (2) and 25 (1) (2), National Assistance Act, 1948.

At the request of the National Assistance Board, the arrangements whereby the Corporation provided a Reception Centre was terminated. Accordingly the female section at Newhills Home was closed on 31st July, 1956, and the male section at 33, East North Street, closed one month later.

From the beginning of the year to the dates mentioned, Reception Centre accommodation was provided for males on 202 occasions and for females on 4 occasions. Cases now arising are, by arrangement, referred to the National Assistance Board for direct attention.

(i) Removal of Person by Sheriff's Order.

The power to secure, under Section 47 of the Act, compulsory removal of certain persons in need of care and attention is a necessary provision which must be interpreted with the utmost discretion and humanity, and utilised only after all powers of peaceful persuasion have failed. Dealing with such cases may entail lengthy and patient visitation by experienced officers. During 1956, it was not found necessary to invoke the powers of this section, peaceful persuasion having achieved the acceptance of care and attention in 11 cases where the need was really pressing.

21.—WORK UNDER NURSING HOMES REGISTRATION ACT.

During the year, the Corporation had under consideration an application by Mrs. Elsie S. Hutcheon for registration under the Nursing Homes (Scotland) Registration Act, 1938, of the premises No. 9, Polmuir Road. After negotiations with Mrs. Hutcheon, the Corporation registered the premises with effect as from 1st October. The nursing home has accommodation for 22 persons. At the same time, the Corporation cancelled the registration of the premises at No. 5, Devanha Gardens, which was a nursing home with accommodation for 10 persons.

22.—SANITATION, WATER SUPPLIES, AND ANALYTICAL WORK.

Such matters as water supplies, sewage disposal, nuisances, and offensive trades will be discussed in the annual report of the Chief Sanitary Inspector and need not, therefore, be outlined here. Two points, however, may be selected for mention—

(a) Water Supplies.

The City has an ample supply of water, obtained from the upper reaches of the River Dee. The water is filtered and chlorinated. Samples of water are taken regularly from the Dee at Braemar, from intake at Cairnton, from filters at Invercannie, and from taps in the City. These samples are tested bacteriologically and biochemically. The results from all samples taken during the year were satisfactory.

(b) Work of Analyst's Department.

The laboratory has, during the year, provided an analytical service dealing with samples submitted under the Food and Drugs Acts and related legislation. It has also provided similar facilities for dealing with samples taken under the Fertilisers and Feeding Stuffs Act, the Rag Flock and Other Filling Materials Act, and also a number of samples connected with water supplies and effluents have been analysed.

The swimming baths, controlled by the City, have been visited once per week in order to take samples for bacteriological examination. Advantage of these visits is taken to test the water chemically and to ensure that effective chlorination conditions are maintained.

During the year, considerable changes were made in the law relating to food and drugs and consolidated under the Food and Drugs Act, 1956, which came into force on the 1st August. New Regulations have also been made under this Act, and it is hoped that the provisions of the new Act will lead to a more effective control of food quality.. New legislation concerning fertilisers and feeding stuffs became effective on 1st January.

The total number of samples analysed for the City was as follows:—

Food and Drugs Act	788
Milks tested for effective pasteurisation	281
Fertilisers and feeding stuffs	20
Rag flocks	6
Swimming bath waters	270
Miscellaneous	24
	<hr/>
	1,389
	<hr/>

The laboratory also provided a biochemical service within the framework of the Regional Laboratory for the Hospital Board.

23.—STAFF AT 31st DECEMBER, 1956.

<i>Medical Officer of Health</i>	Ian A. G. MacQueen, M.A., M.D., D.P.H.
<i>Deputy Medical Officer of Health</i>	David Barclay, M.B., Ch.B., D.P.H.
<i>Principal Assistant Medical Officer</i>	James M. Wallace, B.Sc., M.B., Ch.B., D.P.H., D.I.H.
<i>Senior Assistant Medical Officer</i>	Dorothy Younie, M.D., D.T.M. & H.
<i>Assistant Medical Officer (Schools)</i>	Henry J. Dawson, M.A., M.B., Ch.B., D.P.H.
	Mary Hunter, M.B., Ch.B., D.P.H.
	Elizabeth C. Laing, M.D., D.P.H.
	Mary Macdonald, M.B., Ch.B., D.P.H.
	Margaret Ormiston, M.B., Ch.B., D.P.H.
	Jean Pattullo, M.B., Ch.B., D.P.H.
<i>Departmental Medical Officers</i>	Marie S. Sutherland, M.B., Ch.B., D.P.H.
	Doreen G. Warnock, M.B., Ch.B., D.P.H., D.R.C.O.G.
	Agnes E. Whitter, M.B., Ch.B.
	Donald Shearer, M.B., Ch.B., D.P.H.
	Margaret S. M. M'Gregor, M.D., D.P.H. (part-time).
<i>Chief Dental Officer</i>	Archibald Hay, L.D.S.
<i>Senior Dental Officer</i>	Vacant.
	Hugh Clunas, L.D.S.
<i>Assistant Dental Officers</i>	Ian Lawrence, L.D.S.
	Mary K. Shepherd, L.D.S. (part-time).
	Two vacancies.
<i>Public Analyst</i>	Thomas M. Clark, O.B.E., B.Sc., F.R.I.C.
<i>Day Administrative Officer</i>	Colin C. Grainger.
<i>Statistician (part-time)</i>	Doris M. Brebner, M.A., Dip.Ed.
<i>Principal Health Visitor Tutor and Senior Health Guidance Lecturer</i>	D. Joan Lamont, S.R.N., S.C.M., Health Visitor's Certificate, Health Visitor Tutor's Certificate.
<i>Assistant Health Visitor Tutor and Health Guidance Lecturer</i>	M. Monica Byrne, S.R.N., Part I, C.M.B., Health Visitor's Certificate, Health Visitor Tutor's Certificate.
<i>Superintendent Nursing Officer and Supervisor of Midwives</i>	Jane A. Stark, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Deputy Superintendent Nursing Officer and Deputy Supervisor of Midwives</i>	Lisetta J. Stephen, S.R.N., S.C.M., Health Visitor's Certificate.
<i>Health Visitors</i>	85 (including 17 vacancies).
<i>Midwives</i>	10 (including 2 vacancies).
<i>Ancillary Nursing Staff</i>	3 (full-time).
	2 (part-time).

Social Worker (part-time) . . . Margaret Bell, B.A. (Admin.).

Supervisor of Nurseries . . . Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate.

Nurseries—

(a) RESIDENTIAL—

Pitfodels . . . Matron—Elizabeth C. Jackson, S.R.N., S.C.M., Health Visitor's Certificate (also Supervisor of Nurseries), 3 Deputy Matrons, 13 Staff Nurses, 13 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 4 Nursery Assistants, 15 Probationer Student Nurses.

(b) DAY—

Charlotte Street . . . Matron—Penelope Sandison, R.G.N., 1 Deputy Matron, 3 Certificated Nursery Nurses, 1 Enrolled Assistant Nurse, 1 Nursery Assistant, 9 Student Nurses, 3 Probationer Student Nurses.

Linkfield . . . Matron—Sheila Mitchell, R.S.C.N., 1 Deputy Matron, 1 Staff Nurse, 1 Certificated Nursery Nurse, 1 Enrolled Assistant Nurse, 1 Nursery Assistant.

Deeside . . . Matron—Grace Florence, S.R.N., R.S.C.N., S.C.M., 1 Deputy Matron, 4 Certificated Nursery Nurses, 10 Student Nurses, 2 Probationer Student Nurses.

View Terrace . . . Matron—Christina Milne, S.R.N., 1 Deputy Matron, 4 Certificated Nursery Nurses, 6 Student Nurses, 2 Probationer Student Nurses.

Old People's Homes—

BALNAGASK—

Superintendent and Matron . . . Mr. and Mrs. F. W. Gibson.

NOS. 3 AND 5, FERRYHILL PLACE—

Matron . . . Annabella M'Millan.

NORTHFIELD LODGE—

Matron . . . Alice M. S. Duguid.

NO. 30, ALBYN PLACE—

Superintendent and Matron . . . Mr. and Mrs. John Wilson.

NEWHILLS HOME—

Superintendent and Matron . . . Mr. and Mrs. D. Adam.

NO. 19, POLMUIR ROAD—

Superintendent and Matron . . . Mr. and Mrs. H. T. Wallace.

Sanitary Section—

<i>Chief Sanitary Inspector</i>	Herbert B. Parry, Sanitary Inspector's Certificate, Meat Certificate.
<i>Senior Assistant Sanitary Inspector</i> .	William Jackson, Sanitary Inspector's Certificate, Meat Certificate.
<i>Fish Inspector</i>	Sydney Howell, Sanitary Inspector's Certificate, Meat Certificate.
<i>District Sanitary Inspectors</i>	5.
<i>Assistant District Sanitary Inspectors</i> .	8 (including 4 vacancies).
<i>Apprentice Sanitary Inspectors</i> . . .	3 (including 1 vacancy).
<i>Probationer Sanitary Inspector</i> . . .	1.
<i>Shops Act Inspectors</i>	2.

Meat Inspection Section—

<i>Senior Detention Officer</i>	William M'Donald, Meat Inspector's Certificate.
<i>Senior Assistant Detention Officer</i> .	William Lorimer, Meat Inspector's Certificate.
<i>Detention Officers</i>	4.

Welfare Section—

<i>Senior Assistant Welfare Officer</i> . . .	James D. Davidson.
<i>District Welfare Officers</i>	3.

Clerical—

<i>Senior Clerical Staff</i>	A. M. Ledingham, Secretary to Medical Officer of Health; V. Anderson; M. M. Barry; A. G. Gall; C. P. Gibson; A. E. Munro; M. C. Veitch; M. A. Wilson.
<i>Other Clerical Staff</i>	General, 16; Clinics, 2; Dental Clinic, 1; Sanitary, 3; Welfare, 3.

Miscellaneous—

<i>Audiometrician</i>	Ruth Hogg.
<i>Orthoptist</i>	Vacant.
<i>Chiropodist</i>	Albert R. Loomes.
<i>Assistant Nurses</i>	2.
<i>Dental Attendants</i>	4 (including 2 vacancies).
<i>Male Visitor, School Health Service</i> .	1.
<i>Domestic Helps</i>	Full-time, 51; part-time, 148.
<i>Drivers and Porters</i>	3.
<i>Rat-catchers</i>	5.

Boarding House—

<i>Superintendent and Matron</i>	Mr. and Mrs. C. Greig.
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